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University of Ottawa

the Canadian Nurse

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VOLUME 58 • NUMBER 12
MONTREAL

DECEMBER, 1962

HIGHLIGHTS

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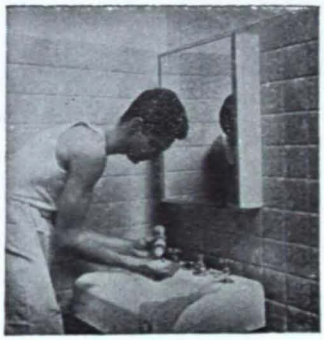

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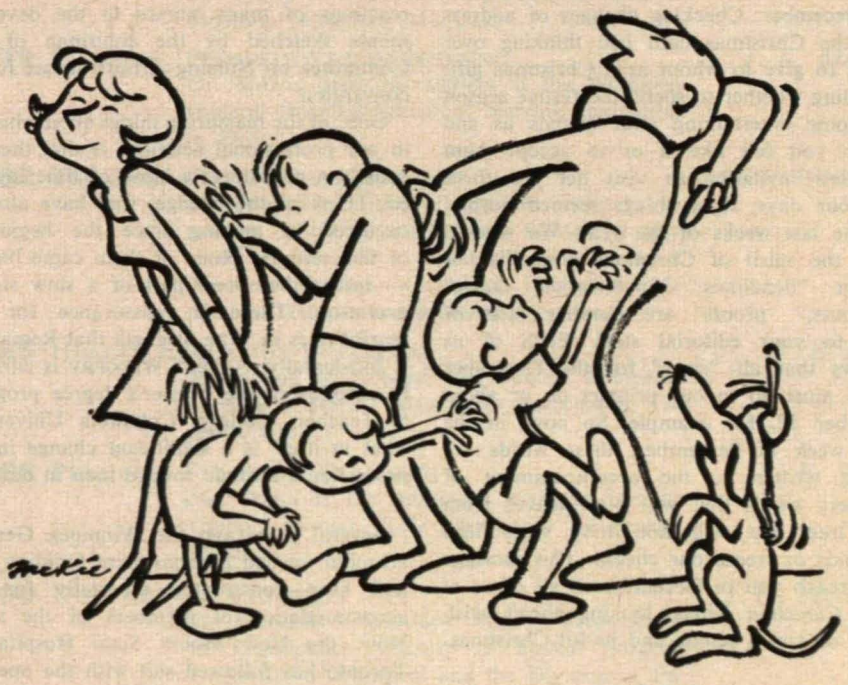

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Between Ourselves

Long before such things as "deadline dates" became an intimate part of our existence, general preparations for Christmas usually began in November, sometimes even in December. Checking changes of address for the Christmas card list; thinking over what to give to whom as a Christmas gift; deciding whether to spend the festive season at home entertaining your friends as and when you felt like it or to accept Aunt Mollie's invitation to visit her for three or four days; these things seemed normal in the last weeks of the year. We worked into the spirit of Christmas gradually.

But "deadlines," "publication dates," "layouts," "proofs" are familiar facts of life to your editorial staff. Each of us knows that all "copy" for the December issue must go to our printers on or about October 12, for example. So now, in the last week of September, these words are being written to the accompaniment of blustery winds that will blow leaves from the trees but will not drive snow into mounds or freeze our cheeks. This message will reach you in December so all of us at *The Canadian Nurse,* looking ahead, wish each of you a serene and joyful Christmastide.

* * *

Variety in the gifts received is the keynote to enjoyment when Christmas parcels are being opened. That principle has guided your editors in the selection of the articles for this Christmas edition. We have tried to line up a variety that will ensure some material of interest for everyone.

Take for instance R. F. SMITH'S "Personal Financial Planning." The experience of the Canadian Nurses' Association in administering their Retirement Pension Plan has shown that while a great many nurses agitated for some such provision year after year, only a very few out of the thousands of nurses who are eligible have taken the necessary steps to enrol in the Plan and thus assure themselves of an adequate income at 65. Perhaps some of Mr. Smith's suggestions may spur these laggards to begin to make some provision for later security.

* * *

Fear of change can be more devastating than change itself. It blurs our thinking to the point that several of the very obvious aspects of change escape our attention entirely. This fear was apparent in the reactions of many nurses to the developments sketched by the chairman of the Committee on Nursing Affairs at last June's convention.

One of the reassuring things about changes in our professional activities is that there is usually a considerable lapse of time involved. Think of the changes that have already occurred in nursing since the beginning of this century. None of them came hastily — rather they were part of a slow steady evolution. There is reassurance for the fearful ones in "The Strength that Remains."

Incidentally, ALBERT WEDGERY is currently enrolled in the Master's degree program at Teachers College, Columbia University. That in itself is a significant change in the professional attitude toward men in nursing.

* * *

Several years ago the Winnipeg General Hospital opened an apartment building that had been constructed especially for the accommodation of members of the staff. Now, the New Mount Sinai Hospital in Toronto has followed suit with the opening of its tastefully appointed, comfortably furnished staff apartments. Close to yet separated from the hospital, this reasonably priced accommodation could be classed as another of the changes we see in nursing.

* * *

We are very pleased with and proud of the new type face that is now being used to print our Journals. It is thinner, blacker and easier to read. Our photographs are being reproduced by a new process that carries a guarantee that the "millionth" copy is as clear and exact as the beginning of the run. Of course we cannot aspire to the million copies each month but it is indeed a source of satisfaction to know that the sixty thousandth in English or the 11,500th French copy will be as well printed as the first ones are.

Other changes will be initiated with next month's issue. Watch for them.

* * *

Look up the little spelling game on page 1078 that is our Christmas present to you.

THE CANADIAN NURSE

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The views expressed in the various articles are the views of the authors and do not necessarily represent the policy or views of The Canadian Nurse *nor of the Canadian Nurses' Association.*

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Description — Wescodyne is a detergent iodine complex which enhances the bactericidal activity of iodine but renders the iodine non-toxic, non-irritating and non-staining when used as directed. The disinfectant is water soluble, stable under normal conditions of storage.

Disinfection is generally accomplished in 10 minutes or less. When used in recommended dilutions, the solutions are of a rich amber color. The color fades as the iodine-complex kills organisms.

Preparation — Cold water is used to dilute Wescodyne, which is not affected by water hardness. It has been suggested by hospital personnel that routine use in hospitals be standardized to a concentration of 75 ppm. available iodine; this is obtained by the following proportions — 3 oz.: 4 gallons of water; 22 ml.: 4800 ml. (1 gallon); 4.5 ml.: 1000 ml. (1 litre).

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Random Comment

Dear Editor:

Greetings from an independent nation. Therefore my theory is to sought for impregnation with individual pen friends (of any age or sex) in your beautiful country of enchantment, henceforth so cordial well consider to spare me the columns of your magazine to be the informant for the purpose of befriendship.

My opinion is to exchange idea, also to know the difference between my country and Canada's condition of sphere, because I depend mostly on this.

Originally an African (Nigerian) boy of 20, with intermediate height and weight also dark brown in complexion. Various letters will be required by Via-Air-Mail which is 25 cents half ounce. I will therefore inform you that you will reign longer and highly commendable. With great felicity of God almighty may bless you for your assistance.

Adios to you all in Canada.

Kenzy Doe,
c/o 11, Isale Agbede Str.,
Lagos, Nigeria,
W. C. A.

★ *Reproduced as received. We were charmed!* Ed.

Dear Editor:

We enjoy receiving *The Canadian Nurse* monthly, and are learning and keeping in touch through the informative articles of each issue.

Betty Lee, Ontario

At the annual meeting of the Central Council of the Canadian Red Cross Society held in Toronto recently, national chairmen reviewed the activities of their committees for the year 1961. Voluntary donors gave 679,319 bottles of their blood during the year, this being a new record for collections. Heart operations totalled 894. These were performed in ten Canadian cities and required almost 19,000 bottles of specially collected blood, an average of 20 bottles for each operation.

—*News of Red Cross*, Vol. 10, No. 4

External heart massage, a non-surgical method of restoring the beat to a stopped heart, is a procedure which should be applied only by carefully trained personnel. Preferably, two qualified persons should participate, one to maintain artificial respiration by mouth-to-mouth breathing, while the other massages the heart externally through regular hand pressure over the breast bone. Most authorities hold that respiration and circulation must both be restored within four minutes of the heart stoppage to avoid brain damage. The method has successfully restored the normal heart beat in some cases of stoppage or disruption occurring during anesthesia or surgery or as a result of drowning, electric shock and asphyxiation.

Application of the technique requires a working diagnosis of the victim's condition. It is important to be sure that the circulation has actually stopped because the method involves certain hazards. Reported injuries to patients have included damage to the heart and liver, internal bleeding, multiple rib fractures and puncture of the lungs.

Training sessions are being held for physicians, dentists, selected groups of nurses, and qualified emergency rescue personnel to make the method more widely available while avoiding the hazards of indiscriminate use by the untrained.

—American Heart Association.

* * *

September was the month to begin influenza vaccination for all persons who are most likely to suffer serious consequences from the disease in the predicted widespread outbreaks this winter. Influenza is particularly dangerous to pregnant women and persons suffering from chronic ailments, as well as all persons over 45 years of age. Persons who have been vaccinated before will need only one additional dose. Those who have not been vaccinated should receive two doses two months apart, and the two should be completed before mid-December. Vaccination is especially important for those suffering from cardiovascular, pulmonary, renal, or metabolic disorders; rheumatic heart disease, especially mitral stenosis; arteriosclerotic heart disease; hypertension; cardiac insufficiency; asthma; bronchitis; bronchiectasis; pulmonary fibrosis; pulmonary emphysema; pulmonary tuberculosis; diabetes mellitus; and Addison's disease.

—U.S. Dept. of Health, Education and Welfare.

Cycloid therapy in the joints of chronic rheumatoid arthritics: "... was proven to be simple, safe and effective in the cases studied. There is an immediate, repeatable, beneficial effect of treatment in that pain, muscle spasm and stiffness are diminished in nearly all instances which lasts from forty minutes to two or more hours."*

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and ASSOCIATED PAIN...

In 219 cases under general hospital care: "We have confirmed previously reported observations that the application of this physical modality results in significant, temporary, but repeatable, muscle relaxation in a non-specific manner in a large majority of the cases studied, and that this physical modality has analgesic properties as this relates to pain associated with muscle spasm."*

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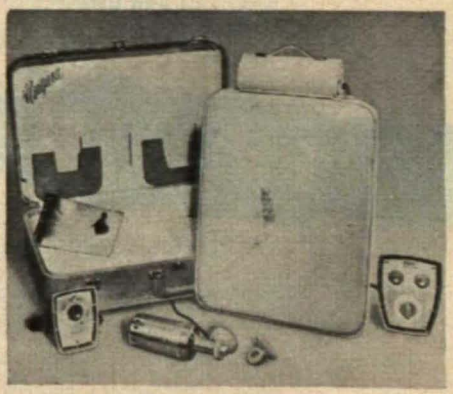

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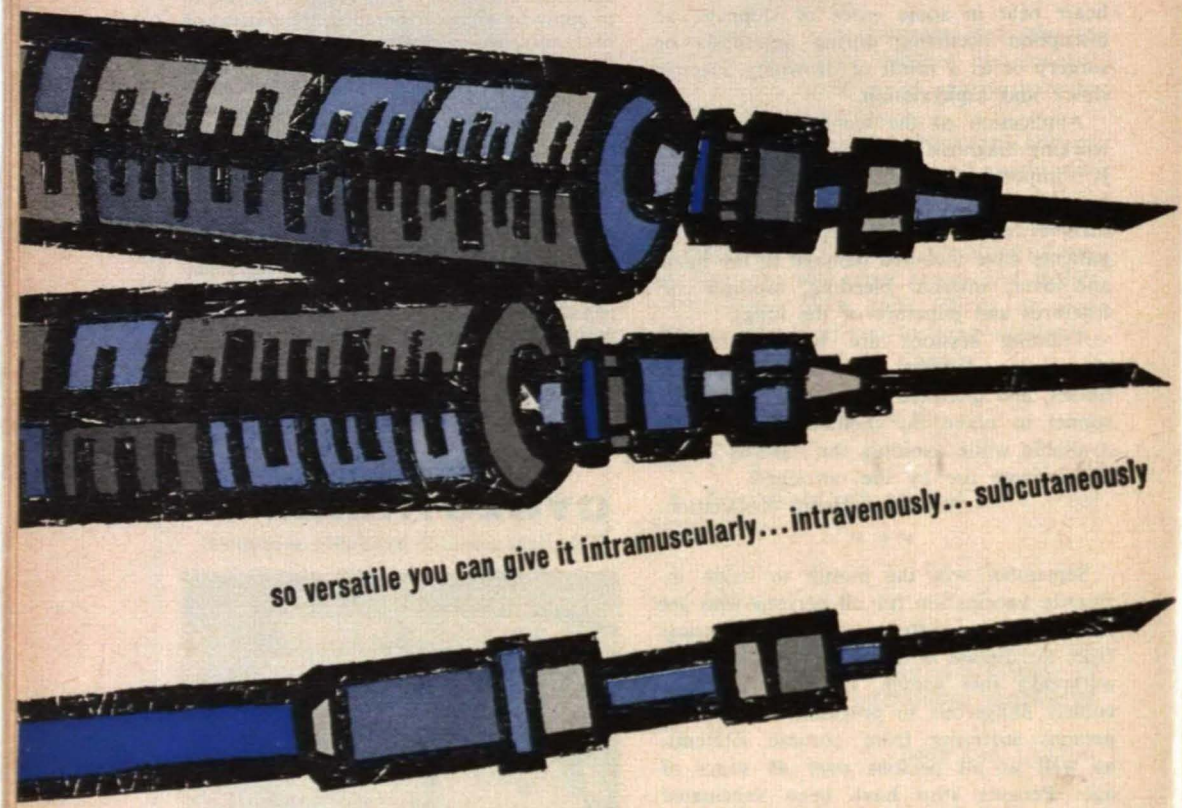

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CHLOROMYCETIN is also available in a variety of dosage forms for oral and topical use.

Warning: Serious and even fatal blood dyscrasias (aplastic anemia, hypoplastic anemia, thrombocytopenia, granulocytopenia) are known to occur after the administration of Chloramphenicol. Blood dyscrasias have occurred after short-term and prolonged therapy with this drug. Bearing in mind the possibility that such reactions may occur, Chloramphenicol should be used only for serious infections caused by organisms which are susceptible to its anti-bacterial effects. Chloramphenicol should not be used when other less potentially dangerous agents will be effective, or in the treatment of trivial infections such as colds, viral infections of the throat, or as a prophylactic agent.

Precautions: It is essential that adequate blood studies be made during treatment with the drug. While blood studies may detect early peripheral blood changes such as leukopenia or granulocytopenia, before they become irreversible, such studies cannot be relied upon to detect bone marrow depression prior to development of aplastic anemia.

Chloramphenicol is a potent therapeutic agent and, because certain blood dyscrasias have been associated with its administration, it should not be used indiscriminately, or for minor infections. Furthermore, as with certain other drugs, adequate blood studies should be made when the patient requires prolonged or intermittent therapy.

References: (1) Ross, S.; Puig, J. R., & Zaremba, E. A.: **Antibiotics Annual** 5-803, 1958. (2) McCrumb, F. R., Jr.; Snyder, M. J., & Hicken, W. J.: **Ibid.**, p. 837. (3) Payne, H. M., & Hackney, R. L., Jr.: **Ibid.**, p. 821.

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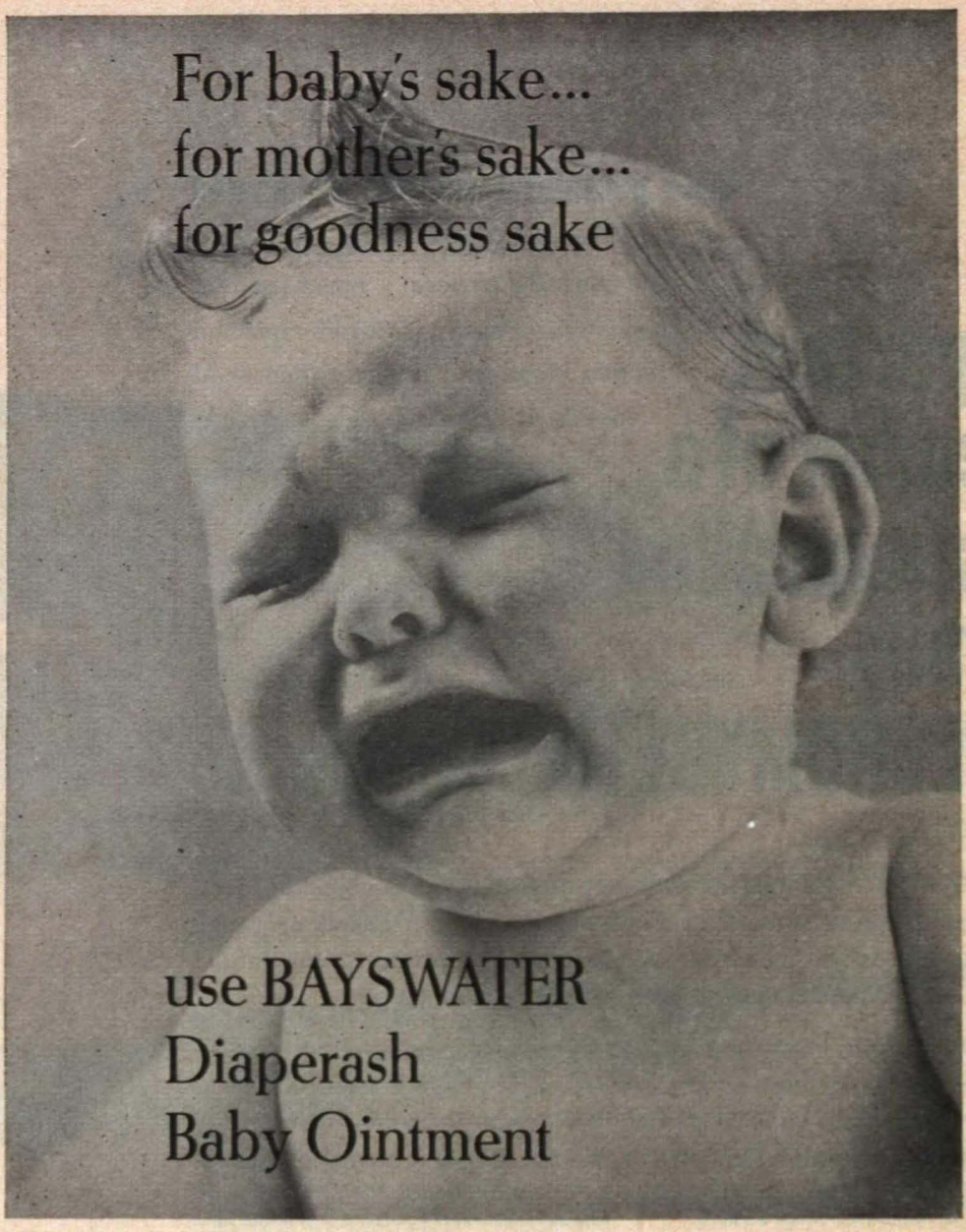

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THE CANADIAN NURSE

A MONTHLY JOURNAL FOR THE NURSES OF CANADA
PUBLISHED IN ENGLISH AND FRENCH
BY THE CANADIAN NURSES' ASSOCIATION

VOLUME 58 MONTREAL, DECEMBER 1962 NUMBER 12

THE GREATEST GOOD

Have you ever had an old acquaintance, whom you had not seen for several years, tell you how much you had changed? What was your reaction? If you are an average woman, you asked her to qualify her statement — in what way had you changed? Was it a change for — hopefully — the better?

An individual's ability to accept change depends upon many factors. Some changes, particularly those involving our material culture, are easy to adopt. It did not take us long to purchase TV sets as soon as they were available! Sociologists tell us that this is because of the importance our society places upon technological developments particularly in the sphere of entertainment.* Any new development that will increase our enjoyment or comfort is enthusiastically adopted.

Changes in non-material culture may be more difficult to accept. If, for example, one of our basic social institutions, the church, attempted to alter its creed, a negative response would be elicited immediately. Church members would form protest groups in a determined effort to maintain the status quo. This aversion to change is understandable. Each member, having internalized his religious beliefs from childhood, places high value on them. The beliefs are an integral part of his personality and he is loathe to allow anyone to make any basic change.

Another factor that influences acceptance of change is the flexibility of the individual. Certain persons seem able to accept change with a minimum of difficulty. Others fear any type of change as a threat to their security. An individual's fear of anything new may lead to personal anxiety — a condition that is seen frequently in our modern dynamic society.

Nursing is faced with innumerable changes. Some will come slowly because of the need for extensive planning, preparation and education of staff. Others will occur more rapidly and may threaten many of the "values"

*Merrill, Francis E., *Society and Culture*, New Jersey, Prentice-Hall Inc., 1957, p. 487.

that we have acquired in our nursing milieu.

It is essential that we separate what is truly a *value* from what may be considered a *custom* of nursing. If we do this, we can concentrate on the more important issues. A value in nursing is total patient care — something that none of us wishes to change. An example of a custom in nursing is the routine of taking each patient's temperature every four hours daily. Many nurses are reluctant to attempt to change customs even though the change is logical and results in greater efficiency. In a recent article in *Hospital Progress,* Eleanor Lambertsen states :

. . . We have operated too long in terms of standards based on emotionalism or fads rather than on basic truths and evidences. Standards must be guides for action based upon broad general principles . . .†

†Eleanor C. Lambertsen, "Where Have We Lost the Patient?" *Hospital Progress,* September 1962, p. 73.

Acceptance of change implies *attitude change.* Many nurses pay lip-service to improvements in nursing education and nursing service without actually accepting them — in other words attitude change has not taken place. Frequently, this lag occurs when changes have been made too rapidly without adequate interpretation to those who will be affected. The pressing need to keep lines of communication open is obvious. Any improvement will falter unless the attitudes of those concerned change along with it.

Each of us has the responsibility to evaluate a proposed change *objectively.* It may be threatening to us; it may require additional work or preparation; il will involve change of attitude; but it cannot be disregarded. Changes that will result in the greatest good for the greatest number must be accepted if the profession is to keep pace.

VIRGINIA A. LINDABURY

In a 38 billion dollar economy such as that in Canada today, about 25 billion dollars worth of goods and services are purchased by and for consumers. Since 1954, two major tendencies have been present in the pattern of consumer expenditure. There has been a steady quarter-by-quarter increase in spending on services, at a greater rate than the rate of increase in spending on all consumer goods and services taken together. This is partly attributable to relatively greater increase in the prices of services than of goods. Spending on durable goods, a category that includes such items as automobiles, household appliances, jewellery, furniture, radios and television sets, has fluctuated widely. Spending in the third broad category, non-durable goods such as food, clothing and tobacco, has risen steadily throughout the period, roughly in line with the increase in total consumer spending.

—*Bank of Montreal, Business Review*

* * *

The more intelligence one has the more people one finds original. Commonplace people see no difference between men.

—BLAISE PASCAL

Men are disturbed not by things, but by the views which they take of things. Thus, death is nothing terrible, else it would have appeared so to Socrates. But the terror consists in our notion of death. That is terrible. When, therefore, we are hindered or disturbed, or grieved, let us never impute it to others, but to ourselves — that is, to our own views. It is the action of an uninstructed person to reproach others for his own misfortunes; of one entering upon instruction, to reproach himself; and one perfectly instructed, to reproach neither others nor himself.

—EPICTETUS

* * *

We teach children that violence is undesirable. Do the newspapers support you? Do television programs support you? . . . Those of us in education are posed with the problem of making young people fit to live in society when the fact is that this is not the problem. The problem is to make society fit for young people to live in.

SIR WILLIAM ALEXANDER,
Secretary of the (British)
Association of Education Committees.

FLUID BALANCE

RICHARD V. MORALEJO, M.D., F.R.C.S.(C)

The purpose of this article is to examine some basic considerations of fluid balance, some of the solutions used in the treatment of disorders, and certain of the common disorders.

Some Basic Considerations

Body Fluids

The average body is made up of 70 per cent water. It is distributed in three compartments, namely, the blood stream (5 per cent), the interstitial area (15 per cent), and within the cells (50 per cent). The first two compartments contain the extracellular water and the third the intracellular water.

Since body water is constantly being lost it must be replaced. The ratio of intake to output is called water "balance." Normal balance requires that intake equal output. For this reason great emphasis is placed on the accurate measurement of the output in the clinical management of balance problems.

Normally, water is taken in by the mouth in the form of food and drink. It goes from the gastrointestinal tract into the blood stream and then to the other compartments. It is normally excreted by the kidney in the form of urine, by the skin in the form of sweat and by the lungs in the form of vapor. There is a constant loss from the skin even when we feel no sweat. This loss is of course greatly increased with profuse perspiration. Normally, there is practically no loss of water from the G. I. tract.

Abnormally, however, the most common losses occur via the G. I. tract as, for example, in diarrhea, vomiting, fistula, suction.

Other abnormal losses can occur from the skin (as in burns), from excessive loss of urine (as in endocrine and kidney disease), or direct loss of blood stream water (hemorrhage). All these losses very often have to be replaced by the use of an "abnormal" route, namely by intravenous or hypodermoclysis.

In summary, water, which makes up more than two-thirds of body substance, enters normally by the mouth and leaves by the kidney, skin, and lungs. It first enters the blood stream, then the interstitial area and finally the cells, and leaves these compartments in the reverse order. Furthermore, in order to remain constant, the intake must equal the output.

But what determines the distribution of the total body water within each of the three separate compartments?

This is due to the selective permeability of the walls of the various compartments to the electrolytes and non-electrolytes in solution in the water.

Body Electrolytes and Colloids

The name electrolyte is given to any substance which, in solution, dissociates into ions with an electrical charge. The three most important ions in fluid balance are sodium (Na^+), potassium (K^+), and chloride (Cl^-). Sodium and chloride are found mainly in the extracellular fluid while potassium is found chiefly in the cells. Normally, these materials are lost chiefly in the urine. They must be replaced by intake in the diet.

The non-electrolytes found in solu-

tion are usually divided into crystalloids and colloids. It is the latter which play a part in normal water distribution, particularly in the determination of blood stream water, that is, blood volume. The chief colloids are the plasma proteins.

Thus, in addition to taking in adequate amounts of water, there must be an adequate intake of sodium, chloride, and potassium and the liver must produce an adequate amount of plasma proteins in order to maintain a proper "fluid balance."

The following are some of the normal values of water, electrolytes, and colloids that are of concern in fluid balance.

Water

1. Intake-output: Normal intake per day — approx. 2,400 cc.

Normal urine output — 1,200 cc.

Normal skin, lung output — 1,200 cc.

Total — 2,400 cc.

2. Distribution: Normal blood volume — approx. 35 cc. per lb. (for example, in a 150-lb. man this volume would be 5000 cc.)

Electrolytes

1. Intake-output: Sodium chloride intake per day varies greatly but it should be a minimum of 4.5 gm. (This is approximately the amount in 500 cc. of normal saline.)

Potassium intake should be a minimum of 40 mEq. per day.

Normal output should be approximately the same as intake.

2. Distribution: Normally, the only one that can be measured is the distribution in the extracellular compartment.

Sodium — approx. 140 mEq/litre

Potassium — approx. 5 mEq/litre

Chloride — approx. 103 mEq/litre

Colloids

These are primarily of concern in "holding" blood stream water. The normal amount of plasma proteins is approximately 6 gm.%

Two other basic considerations concerned with proper understanding of the treatment of disorders of fluid balance are a. acid-base balance and b. nutrition.

Acid-Base Balance

The various electrolytes in solution in the body water tend to give this solution either an acid or an alkaline (basic) quality. Since the body cannot tolerate any radical changes in the pH of its solutions there is a buffer system which prevents the solution from becoming too acid or too basic. It is important, therefore, while treating fluid balance disorders, to restore the buffers and to correct any imbalance that has occurred in this system.

The most common way of determining imbalance is by measuring the buffering reserve (CO^2 combining power) of the blood. The normal CO^2 combining power of serum is approximately 25 mEq/l.

Nutrition

Nutrition is of concern because many fluid balance problems involve long-term intravenous therapy and it is obvious that in addition to water and electrolytes we must provide "fuel". This is usually given as glucose. The 50 gm. of glucose (dextrose) in 1000 cc. of 5% glucose in water will provide 200 calories. 2,500 cc. of 5% glucose will give only 500 calories which is about half the absolutely basal requirement of calories daily. For this reason, attempts have been made to develop intravenous fat solutions which contain about twice the number of calories per cc. as the glucose solutions. To date, these have not been entirely successful. Intravenous amino acid solutions have also been used, but it has been shown that the amino acids break down into glucose unless, at the same time, adequate caloric intake is being provided by other means.

Although not adequate, the provision of 500 gm. of glucose per day is the best that we can do and has been shown to minimize body protein breakdown.

Some Solutions

Colloidal Solutions

Colloidal solutions include blood, plasma, and the plasma expanders, for example, Dextran. The colloids assure that the water will remain in the blood stream compartment. These solutions are of prime importance in treating shock, where there is an acute, severe loss of blood stream water.

Non-Colloidal Solutions

Non-colloidal solutions include :

5% Glucose (dextrose) in water

normal saline, which contains 0.9% NaCl.

5% glucose in normal saline

3% saline, so-called hypertonic saline

0.6 molar sodium lactate solution

Potassium chloride (KCl) is often added to all of these. The amounts are as necessary and usually in multiples of 40 mEq.

"Gastric replacement solution" or "duodenal replacement solution" contain the various electrolytes in the exact proportions found in the solutions that they are replacing. Others are amino acid solutions, fat solutions, or special sugar solutions used primarily to correct nutritional defects.

All of these non-colloidal solutions pass rapidly through the blood stream compartment into the interstitial area and then into the cells. They are used, therefore, in the treatment of deficiencies in these compartments.

Some Common Disorders

Acute Blood Stream Water Loss

Acute blood stream water loss with resulting shock can be due to loss of whole blood through hemorrhage, loss of plasma as in burns or even loss of just water as in sudden high intestinal obstruction.

The concern then is with the rapid replacement of the lost blood volume. For reasons mentioned previously, this must be accomplished with one of the colloidal solutions. The best one is blood but, since its procurement requires time for cross-matching, plasma or plasma expanders may be used. Because plasma is not too readily available and entails some danger, the plasma expanders (Dextran, PVP) are often the first line of defense in the treatment of this class of disorder.

How much colloidal solution must one give? This will depend on the amount lost. Unfortunately blood volume measurements are not too easily accomplished and one often has to go on empirical grounds. In this respect we know that where frank clinical shock (B. P. less than 70 systolic) is present probably more than 30 per cent of the blood volume has been lost.

Desalting Water Loss

Desalting water loss may be a pathological loss via the kidney or the skin or, much more commonly, a pathological loss via the G. I. tract.

The classification of losses from the intestinal tract depends on the electrolyte composition of the fluid lost and the rate at which it is lost. Thus, in the case of high obstruction (for example in the pylorus), associated with the vomiting of highly acid gastric juice, there is dehydration characterized by a marked lowering of serum chlorides and a high CO^2 combining power, a hypochloremic alkalosis. Later on there is a lowering of serum potassium with a resultant hypokalemic alkalosis. Treatment involves replacing the lost water as well as lost chlorides and potassium in such a way as to correct the acid-base balance. In practice this is often done by replacing the lost gastric juice, volume for volume, with normal saline in addition to giving the normal daily requirements. For example :

A patient is losing 3000 cc. of acid gastric juice per day as measured by suction or vomitus. Replacement will require :

2000 cc. of water (with glucose)

500 cc. of normal saline (with 40 mEq. KCl) as normal daily requirement

3000 cc. of normal saline (with glucose) as replacement for lost gastric juice

Total 5500 cc. per day.

In the case of severe diarrhea, loss of ileal contents, or, especially, loss of pancreatic juice resulting, for example, from a fistula, there is a preponderant loss of base, especially sodium. Treatment will require replacement of lost water and correction of the acidosis. Sodium molar lactate solution may be used to replace G. I. losses in addition, as always, to the daily basal requirement.

The amounts given in all these cases depend on the measured losses. Too much emphasis cannot be placed on the importance in fluid balance problems of the *accurate measurement of losses*.

Acute Renal Insufficiency

A problem of overhydration occurs when due to some damage, most often

to shock, there is a kidney shut-down. In order not to "drown" the patient the amount of fluid given must not exceed that which is lost from skin and lungs. In addition, no potassium may be given. Such a patient might receive 1200 cc. of glucose in water per day until such time as the kidney function returns to its normal state.

Conclusion

There are many more examples of fluid balance problems. The management of some of these can be extremely difficult. The basic considerations, however, remain the same for all.

How Do You Spell That Word?

Recently, a popular monthly presented a spelling test of familiar yet frequently misspelled words. Here is an opportunity for you to test your ability on words that are more explicitly applicable to medical and nursing usage.

Before you look up the correct answers check your choice of each of the following spellings. Then, turn to page 1087 for the scoring list. Count up your errors, multiply that number by 2 and substract it from 100. Score yourself as excellent if you have all of the words right or 100%; very good with 86-100%; fairly good with 72-84%; below 70%, ask your friends for a medical dictionary for Christmas!

1. (a) accesory (b) accessory (c) acessory — 2. (a) accomodation (b) acomodation (c) accommodation — 3. (a) blepharitis (b) bletharitis (c) blephtharitis — 4. (a) cirrhosus (b) cirrhosis (c) chiroses — 5. (a) detumescence (b) detumessence (c) detumesense — 6. (a) diapragm (b) diaphram (c) diaphragm — 7. (a) diarhoea (b) diarrhoea (c) diahrroea — 8. (a) diphteria (b) diptheria (c) diphtheria — 9. (a) distrophy (b) dystrophy (c) dystrophe — 10. (a) diuresis (b) diurresis (c) diuresus — 11. (a) dyssynergia (b) dissinergia (c) dysinergia — 12. (a) erasipelas (b) erysipelas (c) erysipalis — 13. (a) erethrocyte (b) erethrosyte (c) erythrocyte — 14. (a) eustachian (b) eustatian (c) eustashian — 15. (a) exaspercation (b) exacerbation (c) exascerbation — 16. (a) falloppian (b) faloppian (c) fallopian 17. (a) fachia (b) fascia (c) fassia — 18. (a) firuncle (b) furruncle (c) furuncle — 19. (a) hemapoiesis (b) hemmapoeisis (c) hemopoesis — 20. (a) hemapheliac (b) hemophiliac (c) hemmophiliac — 21. (a) hemmorhoid (b) hemorhoid (c) hemorrhoid — 22. (a) inoculation (b) inocculation (c) innoculation 23. (a) intermittant (b) intermittent (c) intramittent — 24. (a) intervenous (b) intravenous (c) introvenous — 25. (a) intussusception (b) intussuseption (c) intussusseption — 26. (a) iridenclisis (b) irridencleisis (c) iridencleisis — 27. (a) jugalar (b) jugulur (c) jugular — 28. (a) labirynth (b) labyrinth (c) labrynth — 29. (a) lysis (b) lysys (c) lysus — 30. (a) malloclusion (b) maloclusion (c) malocclusion — 31. (a) malenoma (b) melanoma (c) melonoma — 32. (a) meniscectomy (b) menisectomy (c) menissectomy — 33. (a) mexedema (b) mixedema (c) myxedema — 34. (a) metorrhagia (b) metrorrhagia (c) metrorragia — 35. (a) nepropexy (b) nephrophexy (b) nephropexy — 36. (a) neurasthenia (b) neurosthenia (c) nuerosthenia — 37. (a) occured (b) ocurred (c) occurred — 38. (a) onomatopaiesis (b) onomatopoiesis (c) onomotopoeisis — 39. (a) opthalmology (b) ophthalmology (c) ophtalmology — 40. (a) paroxisym (b) paroxysym (c) paroxysm — 41. (a) pemphigus (b) pemphigis (c) pempigis — 42. (a) phagacitosis (b) phagocitosis (c) phagocytosis — 43. (a) pharingeal (b) pharyngeal (c) pharyngele — 44. (a) perscription (b) prescription (c) presscription —45. (a) pruritus (b) puritis (c) puritus — 46. (a) psorrhiasis (b) psorhiasis (c) psoriasis — 47. (a) rythmic (b) rhythmic (c) rhythymic — 48. (a) vacination (b) vacsination (c) vaccination — 49. (a) vessical (b) vesicle (c) vessicle — 50. (a) visceral (b) viseral (c) visseral

Changing Perspectives in Nursing

JEFFERY E. MORRIS, M.D.

In reply to the frequently heard remark "Nursing is not what it used to be," the author asks: "Why should it be?"

1857 versus 1962

Nursing is not what it used to be. This annoying remark is made by elders in the nursing profession and by medical practitioners who have witnessed the many changes in nursing and medical practice in the past 20 or more years. It is repeated frequently enough and with sufficient passion to demand further enquiry.

The initial reaction to this provocative statement is to answer "Why should it be?" Society is not what it used to be. Medical practice is not what it used to be. The requirements for hospitalization are not what they used to be. In fact, very little *is* as it used to be. The parents of present critics and their grandparents probably voiced the same commentary of the nursing profession in their time. Sir William Osler remarked that "truth has well been called the daughter of time and points of view change with successive generations." One has to look back only 100 years to the time when the first organized school for nurses was established in Great Britain by Florence Nightingale. The majority of ward nurses needed no training except in bed-making and in the preparation of poultices. Those were the days before temperature charts and nurses were not required to be literate. Junior nurses cooked and scrubbed for the seniors as well as for their patients. Some nurses stayed on night duty for a year or more. They were the ones who resorted most liberally to unethical behavior and helped to give nursing the bad name it had then.

"Nursing is not what it used to be." How true! The average lot of a hospital nurse of early times was described by a physician in an issue of *Lancet* in 1857:

> . . . lectured by committees, preached at by the chaplains, scowled on by the treasurer, scolded by the matrons, sworn at by the surgeons, bullied by the dressers (interns), grumbled at by the patients, insulted if old — they are just what any woman might be, exposed to the same conditions — meek, pious, saucy, careless, drunken or unchaste according to circumstances or temperament, but mostly attentive and rarely unkind.

Nursing was neither a vocation nor a profession. Reform came with the spiritual, dynamic leadership of Florence Nightingale in 1860 when the nursing school at St. Thomas's Hospital was established. With this background for the nursing profession in just over a century, it is hard to know where the critics take their points of reference in time. Let us suppose that they do not mean 100 years ago but rather 20 or 30 years.

In order to see the changes that

nursing has undergone in this generation, it is pertinent to examine the scene as a whole and to see how the profession has adapted to the problems that have developed from socio-economic progress and advances in medical science. Thirty years ago the average person saw a doctor once or twice a year. Now he sees him five times a year and even more often if he is a city dweller. Urbanization is only one of the factors that has changed this incidence. Other causes are the general improvement in the educational and economic status of people; the extension of medical insurance of various categories; a general increase in health awareness. There has been an increasing trend towards office versus home practice and a greatly increased usage of hospital facilities. People used to go to the hospital only as a desperate, last resort. Today, they go for treatment and investigation at a much earlier stage of illness. This trend, together with the population growth, has put an almost overwhelming strain on hospital resources and on the allocation of nursing service. There is a tremendous diversification of nursing and medical services. These specialties were nonexistent 20 or 30 years ago. Formerly, a medical team consisted of a doctor and a nurse. Today, it includes a great number of persons with special complementary skills. For example, at least 15 persons may be needed in the operating room for the repair of a congenital lesion of the heart. Over 100 medical specialists, nurses and highly skilled technicians may be involved in the preparation for and the performance of the operation and in the post-surgical care of the patient. These are some of the reasons why nursing is not what it used to be.

The nursing profession, like all others, derives its shape and direction from the society it serves. The number of scientific disciplines now impinging on medicine and nursing, and rapidly becoming indispensable to their practice, are more numerous every passing year. There is no risk of a nurse being unemployed. Each year brings a greater work load for the instructor, the staff nurse and the student. With specialization in medicine heralding a different breed of doctor, he too expects a different type of nursing education to augment and complement medical and surgical management with its new techniques and skills. We now have specialties within specialties. Modern therapy requires it to a degree undreamed of 30 years ago. There must be a point where the importance of seeing the patient as a whole person balances the virtues of extremely specialized knowledge.

If the nursing profession is to meet these challenges, two things are clear. First, we must have more nurses. Second, we must make the most effective use of the time and energy of the nurses we now have.

Cause and Effect

The question of recruitment of nurses has been a focal point of discussion in both the medical and nursing professions. There is an apparent shortage of nurses. A generation ago, only two professional careers, teaching and nursing, were available to a girl graduating from high school. Today, she considers a wide choice of careers — social work, journalism, commerce, medicine, science, etc. All of these compete with recruitment into nursing. In spite of this competition a nursing career is made attractive enough to graduate more nurses each year. Why does a shortage exist?

Not long ago nurses worked a 56-hour week. Now they work a 40-hour week and this has necessitated additional staff. Shortages are occurring in general hospitals which are expanding due to the impact of national hospital insurance plans. Prepaid medical care plans cause greater utilization of clinics and other health facilities which require nursing services. The opening of new economic developmental areas with increase in local populations has also had an impact on the nursing pool. Many new and attractive fields for nursing experience are now available. Public health services on a national and international scale, rehabilitation services and the care required for the mentally ill have attracted nurses to specialized areas. The demand for nurses has risen and, although the supply has increased, it is being outpaced.

Various methods to conserve the nurse's time and energy have been devised. She is assisted by numerous

subordinates : the practical nurse, the nurse's aide, the medical orderly, the ward clerk, the ward worker and voluntary organizations performing part-time comfort duties. Electronic devices are being developed to monitor the patient from the nursing station. The nurse can push a button to read a patient's temperature or to see him on closed circuit television. These devices have been so effective, that the monster created has nearly consumed the poor nurse. She finds herself pushed away from her traditional place at the bedside and forced to occupy a supervisory role in which she plans how the new equipment and the rest of the team can best relieve her of her bedside duties. This is the Frankenstein with which nursing is faced. Basically it results from an extension of Parkinson's law as applied to nursing.

"Nursing is not what it used to be." This statement is worth reiterating. The aspect which is most deplorable and to which most recriminations are applied is the fact that *nurses are no longer in a position to nurse their patients at the bedside.*

The Nurse's Right

What is the solution to the dilemma? It lies in an appreciation of the problem and in the nurse retaining her primary right and duty to be at the bedside. Every patient in hospital is sick in body and to some extent, sick in mind. Understanding the emotional needs of patients is becoming increasingly important as a factor in their physical recovery. Students should be taught to be good listeners. It is as important to soothe the mind as it is to massage and soothe the tired back. Five minutes spent in chatting to a patient is not five minutes wasted. The accumulation of various categories of ward personnel should permit the nurse more time for kindness, empathy, patience and understanding — those indispensables in the treatment of physical disease.

Two Kinds of Nurses

There has to be an understanding that the problem is not solved by diluting the nursing force with auxiliary personnel. It will be solved by strengthening enrolments, increasing the size of nursing schools and delineating various areas of responsibility in nursing to those with specific aptitudes. Some thought should be given to separate teaching programs for undergraduates who are interested either in learning special skills or in becoming bedside comforters. An experiment of this kind may not appear practical because of the immediate obligations that schools of nursing have to supply the demand for conventional graduates. However, the long-term results may be most rewarding.

A Possible Solution

"Nurses are not what they used to be." This may appear to be true because of the quandary in which the graduate nurse finds herself. Confronted by masses of paper work, administrative duties and diversionary activities, she is prevented from providing sufficient hours of nursing care to her patient. Most nurses are greatly concerned about this problem. Nearly every student who enters nursing wants to nurse the patient at the bedside. The nurse is unchanged in her motivation. She would welcome more bedside nursing hours. What are the readjustments which would be necessary to provide for this? In order to save nurse-power, ancillary help in the non-professional areas has to be employed : ward clerks, orderlies, maids, technicians, messengers, etc.

Should revision of the nursing curriculum be required, it must be undertaken not only by the nursing educators but also in close harmony and liaison with the medical profession whose needs have to be understood and taken into consideration. It is hard to believe that any revision of curriculum could be initiated or indeed be satisfactorily completed without representation of medical opinion. Essentially, nursing and the medical profession have to resolve these problems together, both appreciating each other's difficulties with candor, frankness and tolerance. This is long overdue. Curriculum changes have to provide for more active teaching by the medical profession, in the classroom as well as at the bedside and in particular, in areas where rapid medical advances are being made, for example, in cardiac surgery, resuscita-

tion techniques in cardiopulmonary diseases and the surgical transplantation of organs.

Perhaps the student may be eligible for early specialization in the last months of her training. She would then be prepared for reception into a specialized area following graduation. At the same time the nurse who is not interested in learning special skills will become the specialist in bedside nursing.

These problems are not for the graduate of the next decade. These are your problems. They have arisen in your time. Among you are the future counsellors and nursing educators of Canada. Yours is the generation to solve the dilemma and to prove that *nursing is better than it used to be.*

The Strength In What Remains*

ALBERT W. WEDGERY, R.N., B.SC. N.

Today it has become trite and commonplace to say that we live in the throes of change. That we are living in one of the great transitional periods of history is by now widely accepted.

There is scarcely a field of human endeavor that has escaped some alteration in its character or some quickening in its activity. Bold innovations, designed explicitly to break loose from the restrictions or implications of tradition, attest to the growing complexities of life in a technological and rapidly changing social environment. Everywhere the old is being questioned, the new is being hailed. Throughout our society the gulf that exists between the world of values and the world of material success has brought on a state of fundamental crisis.

Nursing, caught no less than other institutions in the struggle to find a workable compromise between the past and the present, bears the imprint of this crucial time. To those striving, often against formidable odds, to preserve its ideals and essentials in the face of realities, "the homely beauty of the good old cause"[1] is being reshaped into a strange, uncertain image. The traditional constitution of nursing has been widened into new dimensions, and the once rigid concept of the nurse is undergoing a similar transformation. Nursing functions are being extended and reinterpreted constantly in the light of outside pressures and through self-criticism from within. Nursing education is now a heterogeneous mixture of shapes and styles, unsettling in its total effect and bewildering in its ramifications. Nursing service has become a patchwork of personnel the diversity of which defeats every sincere attempt to enunciate a proper definition of function. Hence, the new and the old, both contending for equal prominence in the changing landscape, have yet to fuse into an acceptable formula which will restore a professional homogeneity to the entire nursing force.

We must admit that much of the present heartache in nursing comes

*The title is taken from Wordsworth's Ode, "Intimations of Immortality :"

"Though nothing can bring back the hour
Of splendour in the grass, of glory in the flower,
We will grieve not, rather find
Strength in what remains behind;"

from clinging to goals that have remained fixed when they should have been flexible. This is tantamount to the equally fatuous proposition that all our problems could be solved by going back to "the good old days." When beset by doubt and confusion, the tendency is to "look before and after and pine for what is not[2]." Do we wish nothing more from our striving profession than a return to the past or the maintenance of a fluctuating status quo? Can we not learn how to take out of change those things that will fit our needs and to relinquish those objects which new conditions place beyond attainment? This does not mean that we should subscribe only to a philosophy whose value lies in turning away from the old. Nor should we pass lightly to the new lest we weaken the inmost essence of nursing. The important thing is to know how to take the best ideas of the past and modify them to fit a different setting.

We appreciate that the traditional pattern of nursing will no longer serve society. Modern life has made us broaden our horizon to encompass concepts and procedures that were undreamed of a quarter of a century ago. This remarkable change in the face of nursing is positive evidence of its capacity to assume new guises in order to meet today's needs for health services. The American writer, Amy Lowell, has said that "only a vigorous tree has the vitality to put forth new branches." If nursing had lacked the resourcefulness to alter its once stable structure in an effort to keep pace with social and scientific developments, its primary obligation — to provide a continuous service to the public — would have been seriously threatened.

To assume, however, that nursing has changed so radically that the examples of a former time no longer apply is unrealistic. Much of the past we want to forget, it is true, but not until we have learned its lessons. The man is brave indeed who plans his new world without some reference to the old. Yet, we must remember also that the worthy part of the past is only that which is contemporary in its significance and illumination. How can we be certain that every innovation is a step toward improvement unless we have measured it first in relation to the unchangeable essentials of our profession? Nowadays, in our haste, in our detachment, in our yielding to pressures, it is so easy, as Dorothy Percy wrote, to let these constant values get "hidden among the stuff[3]" of modern nursing. While it is necessary to discard outworn habits and sentiments and open the way for experiment, we must hold our gains through the trials of readjustment. There must be no relaxation of the spirit that motivated the nurses of yesterday and will spark the expanding role of tomorrow's practitioners.

What in nursing, then, is unchanging in its essence and emotions? It might be difficult to arrive at universal agreement on this point, but there are certain qualities, technical competence always understood, which are indispensable. Interest, sincerity, kindness, sensitivity, judgment, insight, acceptance — these every nurse must possess to bring the fullest meaning to everyday performance. Here are these same essentials translated into achievement :

> The satisfaction of knowing that the patients we have cared for have received the best possible nursing care, the utmost in understanding, the greatest degree of tolerance[4].

The blending of these attributes into a meaningful personal service to society is the corner-stone of our calling, the strength that remains through all our vicissitudes. Nursing has changed her garments many times, but under each new habit she continues, and will continue, essentially the same.

In other words, there is no replacement for this "good old cause," regardless of how nursing may alter outwardly or its functions increase to accommodate new responsibilities. The humanitarian factor underlies the basic reason for being a nurse; it is the *sine qua non* of every nursing act, large or small, intended to meet, in health, sickness, or rehabilitation, a particular need at a particular moment. How beautifully Virginia Henderson has expressed it. To her the nurse is

> temporarily the consciousness of the unconcious, the love of life for the suicidal, the leg of the amputee, the eyes of the newly blind, a means of locomotion for the

infant, knowledge and confidence for the young mother, a 'mouthpiece' for those too weak or withdrawn to speak[5].

Does not this explain the inner necessity and impulse which moulds nursing to a definite purpose and places the nurse in a strategic position in the total health program? "Of all those who are engaged in the promotion of health it is the nurse who spends the most time with the patient[6]." This is the sum and substance of nursing's unique role in therapy, the old wine we must pour into the new bottles being shaped today so that its stimulating properties can permeate the emerging framework of tomorrow's profession.

Let us dispel at once any suggestion that giving of oneself in service implies inferiority of status. Nursing is "the most personal, vital service that one human being can give to another[7]" writes Evelyn Pearce. There was a time, not too remote, when the work of the nurse was thought to be degrading, but in the last 100 years it has been exalted from its low degree. Nursing lends itself to an understanding of man. It can be an enriching experience which draws its strength from life because its roots lie in fundamental human requirements :

> As we help to fulfill another's needs, his responses tend to fulfill our own. As we give freely of ourselves to an individual or group, we receive the sense of shared activity which is the basis for wholesome personal relationships[8].

This unfailing psychological compensation is the key to nursing's continuing appeal, despite its heavy demands, to those who seek a philanthropic outlet for their talents and abilities. The ideal of serving others, of contributing to the betterment and happiness of human life, is the permanent link in the long chain of nursing that reaches from the shadows of the past into the dimness of an unknown, but expectant, futurity.

Thus, we need not fear the flux of change and struggle and selection so long as we let the perspective of history be the safeguard of our cherished values. Moreover, conflict and perplexity are the necessary concomitants of progress; "the mixture which is not shaken decomposes[9]." A certain compound of initiative and competition is required to make any institution survive and avoid stagnation. The chief problem is to reduce the anomalies of our present state to unity and order in line with the goals we have set as a profession and to ensure that each step in the reorganization and consolidation of the nursing force will enable us to grow, individually and collectively, in the effort to reach those goals.

It has been said that only the young can live in the future, and only the old can live in the past. Most of us are forced to live in the present, in a world where tomorrow may have little in common with yesterday. The moral for us as nurses is obvious : We must move with these decisive times without sacrificing the heart and soul of nursing to the pressures and rivalries of a society in transition. If we fail in this manoeuvre, the fault will lie, not in our stars, but in ourselves.

Let us, then, be content with modest advances rather than rushing headlong into new systems that may lead us into further avenues of frustration and uncertainty. Ralph Tyler has stated that "the improvement of nursing rests heavily upon the discovery and formulation of more comprehensive and unified values for the profession[10]." Should we not use this stage in development to simplify and purify our concepts so that we can offer to modern man a truly unique professional service, one that will satisfy our emotions and justify our beliefs ? This would give meaning and purpose and power to each new enterprise, and nursing could move toward a specific fulfillment, assured of its worth, confident of its future.

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Health Education in Canada

FLORIS E. KING, B.SC.N., M.P.H.

Do we think of health education as passing out literature, showing films, talking to individuals and groups, putting on radio and television shows? Is there really a need for health education specialists when public health workers already do this work?

These past few years the term *health education* has become a rather confusing one. Perhaps the reason for this confusion lies in the differentiation between health education as a *process* in which many different health workers are engaged and health education as a *profession* in which individuals with specialized training in educational methods, communicative skills, and organizational procedures serve as consultants to the many health workers.

Health education is more than using literature, films and mass media channels. It is basically a learning-teaching process consisting of working with individuals, groups and communities. Its aims are to influence attitudes and change health-related behavior of these groups. More specifically, health education consists of activities which are directed toward:

Helping to create interest in and definite opportunities for people to learn about health matters;

taking part in studies of community problems or resources, and reaching the people;

assisting in the enlistment of the active cooperation of the people, and in fostering cooperative relationships with health services and related agencies;

assisting in the selection, development, and use of educational methods and media in accordance with local needs and possibilities;

helping to plan and conduct training programs in health education for health workers, school personnel, and staff members of other relevant agencies;

explaining the health services, which are available, to the population; and helping to evaluate health education aspects of the total health program.*

Thus we see that health education is much more than simply giving out literature, showing films, talking and putting on radio and TV shows. It means developing *programs that work* with community groups on specific problems as recognized in that community. Initially, it may be necessary to create an awareness in the community that such-and-such a problem *does* exist.

Health education, as defined, is employed by some official and voluntary health agencies. The recognition of it as a vital public health process is sadly lacking because of misunderstanding of an educational approach and interdisciplinary jealousies.

Prior to 1948, the functions of

**Expert Committee on Health Education of the Public.* World Health Organization Technical Report No. 89, p. 30.

health education were clearly defined in only one or two provinces.† In 1944 the first qualified health educator was appointed in Manitoba. However, the past 13 years have seen considerable growth and acceptance of health education methodology among public health workers. One of the most encouraging steps has been the appointment of Mr. Michael Palko as health education consultant in the Department of National Health and Welfare, Ottawa. At present, almost every province in Canada has a Division of Health Education whose main function is to assist the voluntary and official health agency staff with their educational programs. The National Health grants have been of considerable help in upgrading the level of awareness of the public to positive health and health problems since they provided funds for the development of health education services and for the training of health education specialists.

Saskatchewan has the most ambitious health education program and the largest health education division among all the provinces. Saskatchewan and Manitoba aim at providing health education specialists in each health unit although at times the shortage of trained personnel has prevented the full realization of this ideal. Saskatchewan, which has consistently used National Health grants in support of its activities, is also active in community and school health education, in-service training, staff recruitment and, over the past seven years, in an accident prevention program that is yielding valuable data on accidents in homes and on farms.†

The health education services of Quebec provide consultant and technical assistance to the public health nurse-educators in the local health units. Through this staff, trained at the School of Hygiene, University of Montreal, the routine services of health units are supplemented by health teaching and counselling. Another aspect of health education in Quebec is its unique approach in supporting the training of elementary and secondary school teachers in health education. With assistance from the National Health grants, more than 400 teachers have also received training in health education at the School of Hygiene.†

Although some progress has been made, there appears to be room for improvement. In 1960 the School of Hygiene, University of Toronto, and the Department of National Health and Welfare completed a questionnaire survey of "Health unit services in eight provinces of Canada." The results are based on 116 units or 87 per cent of the eligible units in the eight provinces that returned the questionnaires.

Of these 116 units, 52 indicated they do have a staff member who is primarily responsible for the health education activities of the health unit. The person named as responsible was the medical officer of health in 42 of these units while the health educator was named in 8.

Sixty-one respondents indicated there are organized unofficial groups who study health and other social conditions in their communities; 49 indicated that the medical officer of health is an active participant in these groups.

Eighty-three respondents indicated that private physicians use health education materials provided by the health unit.§

The findings of this survey, although accurate, do not reflect the comprehensiveness of health education services and their potential in health service programs. Nevertheless, this survey does indicate that there are possibilities for improvement.

It appears that the greatest issue facing health education today is to determine whether the approach to education for health should be the responsibility of qualified persons trained in health education and preventive medicine or whether it should remain the responsibility of the multitude of public health workers with their diversified personal approaches, emphases and methods. Here is a decision that will have to be made soon by public health administrators.†

Although the School of Hygiene, University of Toronto, provides a one-

†*National Health Grants 1948-1961.* Department of National Health and Welfare, Ottawa, Jan. 1962.

§*Report of the Survey of Health Unit Services in Eight Provinces of Canada, 1960.* Department of National Health and Welfare, Ottawa.

year certificate course in health education and a two-year Master of Arts degree for those specializing in health education, it has difficulties in competing with the American schools of public health that offer courses leading to the degree of Master in Public Health with specialization in health education in a much shorter period. Most of the American courses are taken along with health officers, public health nurses, nutritionists, statisticians and environmental health specialists. It is also evident that Canadian degree courses in health education are not able to compete with similar courses in the U.S.A. because the demand for health education specialists in Canada has not been too great.

The voluntary health agencies have a particular opportunity to demonstrate good health education principles in community development. This is evident from their concern to employ health education specialists as program consultants, educational directors, etc. A good example of this is the Canadian Tuberculosis Association, and the British Columbia and the Ontario Tuberculosis Associations, all of which employ health education specialists. Furthermore, the Ontario Tuberculosis Association has demonstrated that, by offering bursaries and employment, it is possible to successfully recruit health education specialists to work on its community programs.

The Ontario Tuberculosis Association has particular interest in involving the community in all aspects of its planning and developing preventive and curative measures through active and informed individuals and groups. Through cooperation with the official and voluntary agencies, the 47 local TB Associations in Ontario have accepted the challenge of finding ways and means to become a part of this community development.

By placing health education specialists in the local setting the O.T.A. is attempting to follow through on a comment made at the Fourteenth World Health Assembly which met in 1961:

> As an infectious disease concerns the entire community and not only the individual patient, the success of a control program will, to a very large extent, depend on the ready cooperation of the members of the public among whom the control measures are to operate. Health education plays a decisive role as it promotes a high level of health consciousness and thus ensures a high participation rate by the population in recommended control measures.

The future holds many opportunities for health education development in voluntary and official agencies. How we best develop these depends on us planning and working together for the betterment of the community. George Bernard Shaw once said: "We are made wise not by the recollections of our past, but by the responsibilities of our future."

(Answers to spelling test on page 1078)

1 (b) 2 (c) 3 (a) 4 (b) 5 (a) 6 (c) 7 (b) 8 (c) 9 (b) 10 (a) 11 (a) 12 (b) 13 (c) 14 (a) 15 (b) 16 (c) 17 (b) 18 (c) 19 (a) 20 (b) 21 (c) 22 (a) 23 (b) 24 (b) 25 (a) 26 (c) 27 (c) 28 (b) 29 (a) 30 (c) 31 (b) 32 (a) 33 (c) 34 (b) 35 (c) 36 (a) 37 c) 38 (b) 39 (b) 40 (c) 41 (a) 42 (c) 43 (b) 44 (b) 45 (a) 46 (c) 47 (b) 48 (c) 49 (b) 50 (a)

Business executives are no more subject to the stress diseases of high blood pressure, heart disease and ulcers than non-executives. Comparing the blood pressure, body weight, serum cholesterol and smoking habits of executives and non-executives in a study group of 1,585 salaried employees, 40 to 64 years of age, no significant differences were found in the prevalence of hypertension, overweight and excessive cholesterol.

—Advance Management Office Executive

Personal Financial Planning

R. Fred Smith

A helpful guide to a well-balanced financial program.

Social and economic changes in recent years have established a trend toward basic financial security. Old age pensions, unemployment insurance, hospital benefits, etc., represent the actions of governments in this field. The majority of large employers have participated by means of improving such fringe benefits as group life insurance, group medical insurance, and retirement pensions. These programs frequently provide only a bare minimum of economic security. Personal financial planning is necessary if an individual wishes to provide a more desirable level of economic security during periods of financial stress.

There is no single financial institution which can offer all of the services necessary to sound financial planning. Banks, insurance companies, trust companies, and investment dealers offer a wide variety of services. Obtaining these services in proper proportion involves decisions which must be based upon knowledge and judgment.

The essential components of financial planning can be divided into three categories — insurance, emergency cash reserves, and long-term investments. Individuals will, of course, have a wide variety of financial problems and requirements. However, the variation will be more one of degree rather than the actual nature of the problem.

Emergency cash reserves probably should have a fairly broad basis of definition. They certainly should be available for abnormally large necessary expenses such as illness. In addition, it might be advisable to include voluntary personal expenses such as the purchase of a home or a long-planned trip. Funds earmarked for this function should be available on short notice at a guaranteed value. Savings accounts at banks are, of course, most frequently used for this purpose. Savings accounts at trust companies are also suitable and will usually provide a higher rate of interest. Canada Savings Bonds meet these requirements. An individual should be particularly careful in this field to be certain that any effort to obtain a higher interest rate is not accompanied by any restriction in immediate withdrawal rights.

A reasonably complete discussion of long-term investment planning would require, at least, a rather large textbook. Fortunately, there are investment services that can relieve an individual of some of the responsibility of an involved study of the subject. There are, however, certain important fundamentals which should be clearly understood. There is a distinct difference between the requirements of emergency cash reserves and long-term investments. The former requires immediate guaranteed value. The latter must be planned with a recognition of the impact of inflation. The real value of an investment is the sum of goods and services which it will purchase at some future date. If "dollars" are to be used as a measure of future value, then there must first be a valid assumption re-

garding the potential future value of these "dollars."

In order to have any financial program, the first essential is an income. Therefore, it is logical to provide protection against loss of income as a result of disability. In some cases, employers provide salary continuation clauses for this contingency — cumulative sick leave. It is essential that each individual determine the guarantees available and obtain a disability insurance policy to take over when income ceases from regular employment. Many professional associations now have group insurance plans for their members. Excellent individual disability income policies are also offered by several insurance companies.

Any decision regarding life insurance will depend upon whether or not the individual has others dependent upon her income. Employers frequently provide group insurance which will, at least, meet a part of this requirement. If it is necessary to purchase additional individual life insurance, one should give very careful consideration to Term Insurance or Ordinary Life Insurance. These policies meet the primary requirement of providing the maximum of insurance protection at low cost. Endowments and similar plans do provide reserve funds through their cash values. It must be remembered, however, that withdrawal of the cash value must reduce the insurance value of any policy. This is one of the factors which indicates the general advisability of providing for various financial contingencies independently, rather than by means of a combined service.

In the past twenty years, the true purchasing value of money has dropped approximately 50 per cent. In other words, a dollar saved in 1940 will buy, in 1962, only one-half of the goods and services that it would purchase when it was saved. In order to provide a hedge against inflation, an investment should display long-term growth of capital.

Over long periods of time, common stocks in selected industries have provided investors with growth of capital. However, the risks inherent in common stock investments are a rather prohibitive factor in personal investment planning. There are two essential methods of reducing these risks. The first is an expert knowledge of investments. This can only be obtained by study and experience. The second is diversification in order to reduce the risk of large price fluctuations which might occur in a single stock. It requires a rather large personal investment account in order to achieve the degree of diversification essential for adequate reduction of this risk.

Excellent professional investment management is available through the purchase of mutual funds. The investment management staff of these funds include experts on every important Canadian industry such as paper, steel, oil, and public utilities, to name only a few. These experts select the best industries for investment. Furthermore, they select the companies within each industry which have the best opportunity for future growth. Other specialists study the technical aspect of the stock and bond markets in an effort to regulate the flow of funds on the most advantageous basis. The specialized knowledge of these men is probably the most satisfactory method of avoiding the risks of uninformed stock market speculations.

As these mutual funds represent the savings of a large number of individuals, sufficient money is accumulated to establish a diversified investment portfolio. Obviously, this diversification will be greater than an individual could obtain without the possession of exceptional wealth.

Mutual funds may be obtained from investment dealers or from direct sales representatives. They are probably the most rapidly growing medium for personal investment at this time.

Efficient personal financial planning is not difficult to achieve. It can be readily seen that a few fairly simple tests will indicate the most advantageous method of employing funds for a specific purpose. The small amount of time required in making these decisions will provide the reward of a well-balanced financial program.

A wise scepticism is the first attribute og a good critic. —JAMES RUSSELL LOWELL

DENTITION IN CHILDREN

J. GEORGES PERREAULT, D.D.S., M.S.

The first dentition is the key-stone to a child's future dental health as an adult. The teeth are not only important in speech, in chewing food but also affect the patient's general appearance. Dentitions marred by unsightly defects such as caries or a poor alignment of the teeth may affect the child psychologically. It is evident from this, that dental care has an important role to play in a pediatric health program.

Stages of development

At approximately six weeks in utero the first sign of tooth development appears. This consists of a budding of the mucous membrane of the mouth at each point in the jaws where teeth will later appear. This bud of mucous membrane then grows into the jaws where its cells become specialized to form the enamel of the tooth. The tissues surrounding this specialized mucous membrane are influenced in their turn to form the dentine.

The characteristic shape of each tooth is determined during this early stage by a molding effect of this specialized epithelial tissue, in the same fashion that a mold is used to determine the shape of a metal statue. Enamel and dentine formation begins with the secretion of a matrix by the specialized cells previously mentioned. Mineral salts are then deposited in the matrix to "calcify" it and the end result is enamel or dentine.

The first part of the tooth to be formed is the tip of the crown. Gradually, over a period of years, the rest of the crown and the roots are formed in their turn (Figure 2).

These stages are not independent of one another, their mechanisms are closely synchronized so as to give the structures the quality and size needed.

Normal Eruption of the Teeth

Eruption can be divided into three phases :

1. *The pre-eruptive phase* consists of the formation of the crown of the tooth in the jaw.

2. *The prefunctional stage* includes the beginning of root formation and, at the same time, the tooth begins to move towards the mouth.

3. *The functional stage* begins after the teeth have cut through the gum, and lasts until the upper and lower teeth interdigitate. Since changes occur in the interdigitation or "bite" of the teeth throughout life, this stage can be said to last as long as the teeth do.

Clinically, eruption simply represents the passage of the teeth through the gingiva or gum. The appearance of the first dentition is frequently accompanied by restlessness and pressure pain; however many of the ills attributed to the eruption of teeth seem to be incidental to it, and are probably due to other causes. Most of the time, the apparent pain may be relieved by

painting the gingiva with a dentition syrup in which a topical anesthetic has been included or by allowing the child to chew on a soft rubber toy, making sure that the object cannot be swallowed.

good criterion of the growth and development of youngsters.

As long as the teeth erupt at approximately the normal time (+ 8 months in the primary dentition; ± one year in the permanent dentition)

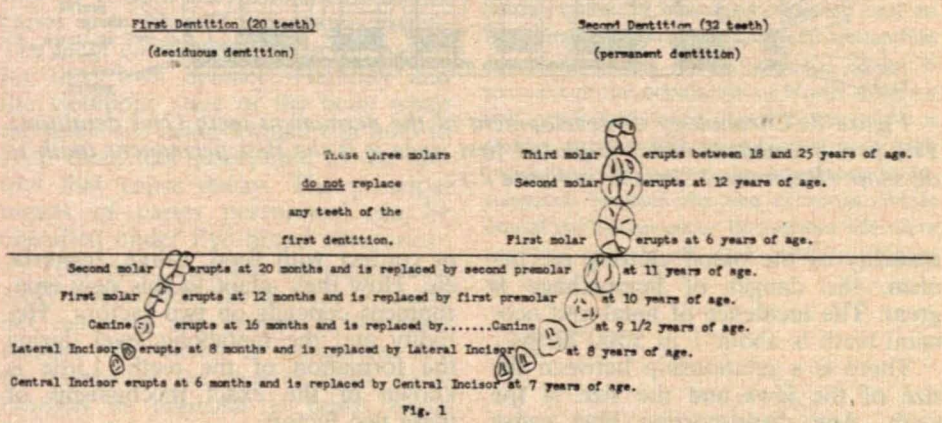


Fig. 1

The average dates given above are for the 10 lower teeth of the first dentition and the 16 lower teeth of the second dentition. Emphasis is placed on the fact that 1st, 2nd, and 3rd molars of the second dentition are not replaced or do not replace any teeth.

The teeth of both dentition appear a short time later in the upper jaw. The eruption schedule for girls is usually earlier than for boys. At about 12 years of age all the teeth of the first dentition have been replaced.

The average eruption time for each tooth has been established, but it should be noted that there is a considerable variation from child to child. The average eruption dates for each tooth can be calculated as indicated in Figure 1.

This order of eruption is seen in about 70 per cent of children. In the others the teeth may erupt earlier or later, or the order of eruption may be reversed, as for example, the central incisors may appear before the first molar in the second (or adult) dentition. The rate of tooth formation is a

one should not be alarmed. However, if the teeth take too long to appear it may be advisable to check for their presence with dental x-rays.

Sometimes, babies are born with a tooth (natal tooth) or one may appear in the month following birth (neonatal tooth). Usually, these do not stay in the mouth. Most of the time they have to be removed because they interfere with nursing or because they may become loose since the roots are usually absent. Caution should be exercised if a natal tooth is to be removed immediately after birth; because of the im-

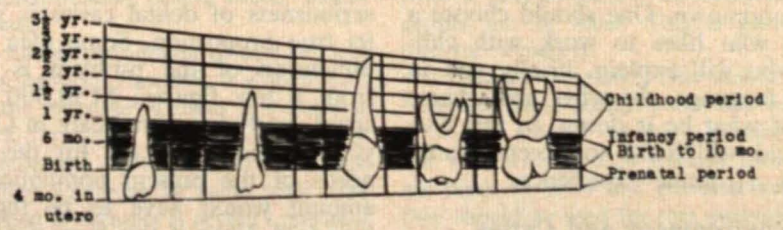


Figure 2. Chronology of development of the primary (1st dentition) teeth (Massler, M. and Schour, I.: "Atlas of the Mouth," American Dental Association, Chicago, 1944).

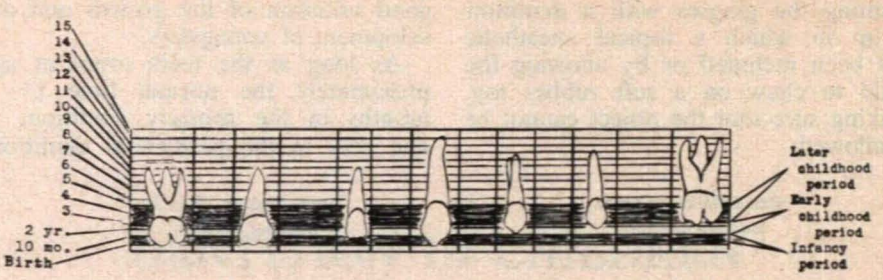


Figure 3. Chronology of development of the permanent teeth (2nd dentition). The first permanent molar is placed first since it is the first permanent tooth to develop. (Reference: Same as in figure 2.)

maturity of the blood clotting mechanism, the danger of hemorrhage is great. The incidence of natal and neonatal teeth is about 1 in 5000 births.

There is a relationship between the size of the jaws and the size of the teeth. Any disproportion may cause a malposition of some teeth. When the teeth seem badly aligned one would be wise to seek expert advice.

The premature loss of some of the deciduous teeth, in particular the molars, may later cause abnormalities in the alignment or "bite" of the succeeding permanent teeth. For this reason it is considered important to keep the deciduous molar teeth for their normal length of time. In cases where premature removal is necessary the dentist may advise the insertion of an appliance to prevent trouble at a later date.

The first visit to the dentist should be made at about three years of age when the child is socially and psychologically old enough to understand. The child should be prepared by his parents for this first dental appointment by explaining, in simple terms, why dental care is necessary and what to expect during the visit; this will lessen the child's natural apprehension of the unknown. One should choose a dentist who likes to work with children who will explain, briefly and in simple language, the whys and wherefores of what he is doing. In this way the child will learn to accept dental care as a routine experience.

Environment and Caries

When the teeth appear in the mouth their environment changes completely. Protected in the gums, they now come in contact with food, saliva, bacteria, etc. How they adapt to this new environment depends on two factors : Heredity and the metabolic level during the formation of the teeth. Little is known of the exact mechanisms of these two factors.

Dental caries is a widespread disease of the hard tissues of the teeth. It takes the form of destruction that progresses inward. This decay is triggered by acids produced by bacteria acting on certain foods, especially sweets.

The rate of speed with which dental caries progresses, varies with individuals. It may be very fast (as in cases of rampant caries) or it may be very slow. Therefore, a good clinical evaluation has to be made. Since initial carious lesions usually begin in awkward regions where they are difficult to detect, a minimum number of x-rays must be taken in order to get the right clinical picture. In many cases if we wait until the caries can be seen, destruction may be so extensive as to complicate treatment. Dental caries attacks 95 per cent of the population so means of preventing it are of the utmost importance.

With the better health standards prevalent in North America today the seriousness of dental caries is seen in its true proportion. Some idea of the dimension of the problem is gained from a few figures; $150,000,000 is spent yearly for dental care in Canada, yet to adequately care for the dental needs of the present population, this amount would have to be increased four-fold. Even if this large amount of money were available, there is not a sufficient number of trained dental personnel to care for the needs of the

whole population. Therefore, methods of prevention are being sought so as to reduce the amplitude of the problem.

Prevention and Caries

As in many other diseases the ideal way to control the problem of dental caries is to prevent it from occurring. The teeth carry within them the means for their own defence. Heredity and the metabolic state of the body when the teeth are being formed can help to keep them less susceptible to the factors that cause decay. The principal means of caries prevention can be classified under five broad categories :

1. *Chemical :* Fluorides can reduce tooth decay 50% to 60%. The best way to achieve this end is to add fluorine to the water supplies. The fluoride is incorporated into the enamel of the growing tooth which increases its resistance to dental decay. Fluoridated water is most effective when given to children whose teeth are still growing.

Where fluoridation of the communal water supplies is not in effect, fluoride can be applied to the teeth by the family dentist. These applications provide their greatest efficacy when done as soon as the teeth erupt in the mouth. Fluoride may also be added by the family to the water used for cooking and drinking purposes. However, addition of fluoride to other liquids and foods seems to be of debatable value.

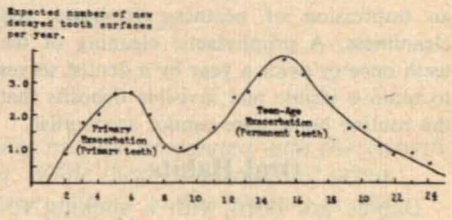
2. *Physiological :* Saliva is an important factor in caries prevention since it serves to cleanse the teeth. However, saliva does not flow at a constant rate. At night, for example, the flow is reduced. Because of this, it is important that the teeth should be brushed thoroughly before retiring so that no remnants of food remain around the teeth.

Saliva can inhibit, to a certain degree, the proliferation of bacteria. Nevertheless, the consumption of certain foods associated with caries formation, chiefly sweets, should be restricted.

Saliva dilutes the amount of acid produced by the bacteria. However, it is important to limit the ingestion of foods that bacteria use in acid formation. Otherwise, the natural means of defence will be easily overthrown.

Clinically, a number of saliva tests have been devised to measure a person's potential caries activity. A saliva sample is analyzed for bacteria thought responsible for the initiation of caries. The number of carious lesions usually varies directly with the number of these bacteria in the mouth. Thus, an increase in the number of bacteria may mean an increase in the number of carious lesions.

3. *Individual susceptibility and tooth morphology :* People are not all affected by dental caries in the same manner and to the same degree. Some are very susceptible to dental decay, others less so. About 6 per cent of the population of North America will never experience dental caries, while a similar number will be subjected to a high incidence. The rest of the population is interspaced between the two extremes. While dental caries can occur throughout life there are two periods of peak activity (Figure 4).



Age in years

Figure 4. Two periods of peak dental caries activity

The first period occurs between the ages of four and eight and the second between the ages of twelve and eighteen. Usually, if competent care is provided during these two critical periods one can say that the patient should be able to keep his teeth reasonably free of caries. After the twenties, diseases of the tissues supporting the teeth account for the loss of most teeth.

One point of extreme importance is that dental caries is a disease of youth. Most of the defects we see in the adult are due to neglect during the adolescent period. Since caries is not a self-limiting disease neglect further aggravates the situation. It is therefore important to visit the dentist at least twice a year to prevent the condition from getting out of hand. This is particularly true for teenagers.

4. *Nutrition and diet :* Diet should be well balanced. Most people know this but only a limited number of them practise it. A few points need to be stressed here. Teeth are made to chew and pulverize food and they should be used for that purpose. Some foods such as steaks and raw fruits, because they have to be chewed vigorously, do help to clean and polish the teeth. On

the other hand, sticky foods like caramel or peanut butter tend to remain around the teeth and provide a playground for bacteria. Since all sweets cannot be cut from the diet, one good rule would be to eat them as a dessert at the end of a regular meal and then to brush the teeth immediately after. For in-between meal snacks it would be preferable to stick to raw fruits and vegetables.

5. *Mechanical adjuncts:* Mechanical means of cleaning the teeth play a big part in the maintenance of good oral hygiene. The tooth brush, when properly used, is an efficient means of cleaning the surfaces and maintaining them free of gross food debris. It also helps to limit bacterial activity in the mouth. Dentifrices like mouthwashes, are cosmetic preparations that help to give an impression of neatness, freshness and cleanliness. A prophylactic cleaning of the teeth once or twice a year by a dentist serves to remove visible and invisible deposits that the routine home care cannot accomplish.

Oral Habits

Babies are born with a sucking reflex. This is a necessary reflex without which nursing becomes difficult. With the change from a liquid diet, to semi-solid food and finally to solid food the reflex diminishes. During the liquid diet stage, periods of thumb, finger, and blanket sucking alternate with feeding.

Many times the intensity of the reflex instead of diminishing remains strong, sometimes becomes even more intense as the child grows older. At this time a few pertinent questions have to be asked. The first one is *why,* the second is *how* and the third is *when* is the child sucking? This third question may refer to the period of the day or to the age of the child.

If, after four years of age, the habit is still strong it would be wise to take a good look at the environment because the habit may be symptomatic of a poor adjustment to the conditions in which the child lives. The parents may be too severe, may not pay enough attention to him, spoil him too much, etc.

If the habit persists but is expressed only at specific times of the day when, for example, the child is tired or hungry, it is better to ignore it. The habit is usually on its way out and should disappear in due time.

Thumbsucking during the period of the first dentition does not usually cause lasting effects, but if intense sucking continues until the onset of the second dentition, the effects may be more drastic. In some instances, this may result in protrusion of the incisor teeth and other abnormalities.

Many other habits affecting the teeth may be acquired during the preschool or early school period, but thumbsucking is usually the most important one. One has to be careful before deciding arbitrarily that a child's habit has to be stopped. If the habit becomes too marked, one should seek competent advice.

Coming!

in

JANUARY 1963

Special Civil Defence Issue

Wrinch — The Army in National Survival
Hardman — Emergency Health Planning
Cameron — Emergency Health Services Advisory Committee
Pepper — Protection of Your Family
Felicitas — Disaster Nursing in the Basic Curriculum
Gemeroy — The Public Health Nurse in Disaster Nursing

plus additional material

Abnormalities in the Growth and Eruption of the Teeth

WILLIAM B. DONOHUE, D.D.S., M.SC.

A brief review of some of the anomalies that may be associated with the growth, development and eruption of the teeth. While these abnormalities occur during childhood they may not become evident to the parents or the patient until he reaches his teens or early twenties.

The growth of a tooth in initiated by an invasion of the oral mucous membrane into the jaws at each area where teeth will later appear. Following this, the cells of the invading mucous membrane become specialized to form the enamel of the tooth, while the cells of the adjacent tissues become specialized in the formation of the dentine.

Under certain circumstances this normal process of penetration and the subsequent specialization into enamel-producing cells becomes altered so that abnormalities in the number and quality of the teeth may occur.

Abnormalities in Number

Less than the normal number

If the mucous membrane lining the mouth fails to grow into the jaws or, once having invaded the underlying tissues, it fails to fulfil its function of producing enamel, tooth formation will not occur. The result is Anodontia, the congenital absence of all or a few of the teeth. The absence of one tooth is fairly common. While any of the teeth may be missing, there is a tendency for some to be absent more frequently than others. Those most frequently missing are the upper lateral incisors, the premolars, and the third molars or "wisdom" teeth.

Occasionally, the absence of a particular tooth may show a familial tendency so that several generations may have individuals with the same tooth missing. Total anodontia is rare. It is usually associated with a generalized condition affecting many of the structures that develop from the skin or mucous membrane in utero. The patient may not only show a lack of teeth, but also an absence of sweat glands or a sparse growth of hair on the scalp.

Extra or supernumerary teeth

The normal complement consists of 20 deciduous or primary teeth which are replaced in time by 32 permanent or adult teeth. Occasionally, this number may be increased, particularly in the permanent dentition, by the presence of extra or supernumerary teeth.

For some unexplainable reason, su-

pernumerary teeth tend to occur much more frequently in the upper than in the lower jaw. While they may occur anywhere in the dental arch, they are most commonly found between the two upper central incisors, or behind the upper third molars.

Because the jaws have only enough space for the normal number of teeth these supernumerary teeth may remain embedded in the jaws, or they may erupt in such a position as to cause a disturbance in the patient's bite or occlusion. The eventual eruption of these embedded supernumerary teeth in later life is the basis for the newspaper reports of a person "growing" a third set of teeth after having worn dentures for years. While supernumeraries may resemble normal teeth, they are frequently much smaller with a cone-shaped crown, hence the term "peg tooth."

Abnormalities in Quality

Defects in tooth formation

Disturbances of a general or systemic nature during the pre- and early postnatal periods, when the teeth are developing, may result in the formation of teeth of poor quality. Nutritional deficiencies, exanthematous diseases, and birth injuries frequently result in teeth with numerous pits and stains on their surfaces.

Any severe disturbance during childhood, a period when the crowns of the permanent teeth are being formed, will result in teeth with defects of either shape or quality. Local factors, such as an abscessed deciduous tooth, may affect the development of the underlying permanent replacement. Thus, when the child reaches adulthood he will have a normal complement of teeth, with the one exception — the permanent tooth may show an ugly pitting, a brownish discoloration, and an irregular crown.

The consumption of large amounts of certain chemicals, either in food, water or as a drug, may also affect the quality of tooth development. The most interesting example of this is found in the history of fluorides. Two midwest American dentists, G. V. Black and F. S. McKay, in 1916 described a peculiar deformity, characterized by a pitting and staining of the crowns of the teeth. They referred to the condition as mottled enamel. They noticed that people with this dental deformity came from specific geographical locations. They reasoned that the cause might be some substance in the water. It was later found that there was a high fluoride content in the regional water supplies. Further studies showed that not only did fluorides cause mottled enamel but they also reduced the incidence of dental decay. Observations indicated that if the fluoride content of the water was maintained at 0.9 to 1.0 part per million a reduction in the rate of dental decay occurred, while defects in enamel formation were rarely evident.

Defects in calcification

Endocrine disorders, such as hypoparathyroidism (tetany), and nutritional deficiencies, such as a lack of vitamin D (rickets), may result in poorly calcified teeth. To cause such defects these deficiencies must occur during the period when the teeth are being formed. Similar deficiencies in an adult would not affect the quality of the teeth.

Unfortunately, once the teeth have been formed any defects that have occurred during their growth cannot be repaired either by diets or drugs. If the patient's appearance is marred by pitted or discolored teeth, the dentist will frequently cover them with artificial crowns.

Abnormalities in Size and Shape

The size and shape of the teeth are inherited characteristics. While their size is usually suited to the size of the jaws, variations may occur. One may inherit teeth that are small relative to the size of the jaws (microdontia), or they may be relatively large compared to the jaws (macrodontia).

Such local factors as an abscessed deciduous tooth may affect the shape and size of its developing permanent successor. Congenital syphilis may produce notched and narrow-edged incisors (Hutchinson's incisors) and distorted molars.

An error in the growth process may result in the fusion of two teeth that are normally separated. This results in

the formation of a tooth with a very large crown.

It is evident that the size, shape and quality of the teeth can vary considerably depending on the sum of the hereditary, congenital, local and systemic influences.

Abnormalities in Eruption

Nutritional deficiencies, if severe enough, can delay the eruption of both deciduous and permanent dentition. This is particularly true in rickets. Abnormalities of the endocrine system, and generalized growth disorders may also affect this eruption. Sometimes the adult teeth never do erupt. An x-ray of the jaws will show many teeth embedded in bone. Fortunately, cases of this kind are not frequent. When they do occur they may be accompanied by abnormalities of the skull and other bones of the body.

A much more common occurrence is the delayed eruption of one or two teeth. This happens because the tooth instead of erupting towards the mouth grows towards a neighboring tooth or deeper into the jaw. This blocks its progress and prevents its normal eruption. Teeth that remain completely or partly buried in the jaws in this fashion, are referred to as embedded or impacted teeth. While any tooth may be imbedded, those most frequently involved are the "wisdom" teeth and the upper cuspids.

Teeth may remain embedded in the jaws because of a lack of space. For example, if a child inherits a small jaw from one parent, and large teeth from the other, there may not be enough room for all the teeth to erupt normally. The last teeth to appear, the upper cuspids and the lower third molars, are forced to erupt out of line, or they fail to develop at all.

Embedded teeth may cause pain in the jaw and neck regions, and they may damage the adjacent tooth. An infection of the gum tissues surrounding the crown of a partially buried tooth, or pericoronitis, is a frequent complication.

Impacted teeth may also be associated with cysts and tumors of the jaws. These growths originate from the epithelium which forms the enamel of the crown. They may attain a considerable size before the patient is aware of them. The treatment, of course, is surgical removal.

The treatment of impacted teeth varies depending on the individual. In many instances, it is advantageous to remove them before complications arise. Generally, the ideal time is during the late teens and early adulthood when they can be removed with a minimum of trauma and complication.

Neoplasms Associated with Developing Teeth

While a variety of tumors can occur in the jaws, the ones most frequently encountered are derived from the cells that form the enamel. These tumors are called ameloblastomas. They are usually composed of soft tissue. They tend to occur chiefly in young adults and grow slowly so that several years may elapse before they are noticed. Unfortunately, they have a tendency to recur following initial removal.

Cysts associated with teeth consist of a cavity sometimes filled with liquid and lined by epithelial membrane. With embedded teeth, cysts will be attached around the crown and are termed follicular cysts. Teeth that have erupted into the mouth may also show cyst formation attached to the roots. These are referred to as radicular cysts. A cyst can attain a considerable volume before being discovered. Periodic dental x-rays serve to detect anomalies of this sort at an early stage.

Occasionally tumors of the jaws may be composed of the hard tissues of the tooth: enamel, dentine and cementum. They are called odontomas, and may include anatomically normal teeth. When odontomas occur they may replace normal tooth development. The patient or his parents only become aware of the tumor when the permanent teeth fail to erupt, or because of swelling of the jaws. Once removed, the growths do not recur.

All generalizations are dangerous, even this one. — ALEXANDRE DUMAS

DESEGREGATION

IN A PSYCHIATRIC UNIT

C. G. COSTELLO, PH.D. *and* M. GAZAN, R.P.N.

When a clinical decision appears to be of therapeutic value, one is reluctant to revert to old methods for the sake of research. The authors are reporting their findings so that those who may be planning the desegregation of patients or any other major change in their wards may consider the possibility of using the Burdock Scale for the objective assessment of their results.

Introduction

One aspect of the increasing emphasis on the social determinants of mental illness* is the attempt to maintain, as far as possible, links with the patient's world outside hospital. Another aspect, related to this, is the attempt to maintain the social skills of the patient while he is in hospital. This is particularly important when one is dealing with long-stay patients. But maintaining a normal living atmosphere within the hospital may also be of therapeutic value to short-term patients, such as one finds in small psychiatric units.

The present study was designed to determine the effects on patients' ward behavior of desegregation of male and female patients.

Method

The study was conducted in the Munroe Wing, a 35-bed psychiatric unit of the Regina General Hospital. The unit is divided into two floors and, before desegregation, the female ward was on the upper floor and the male ward on the lower floor.

Before the change which mixed male and female patients, each of 23 patients was rated independently by two or three nurses on Burdock's Ward Behavior Rating Scale.† Following the change, 23 new patients were rated independently by two of three nurses. These 23 patients were matched with the patients in the first group on age, sex, diagnosis, treatment and length of hospitalization. It had been hoped to obtain ratings from three nurses on each patient. This was not possible and not all of the patients within the two groups were rated by the same nurses. However, there was one nurse who rated all the patients and, in every case, the matched pair of patients was rated by the same two nurses so that any difference between the two groups cannot be attributed to differences between the raters.

In both groups there were 20 female and 3 male patients. The ages ranged from 18 to 73 years with a mean of 39.43 years. The length of hospitalization before the rating ranged from 7 to 110 days with a mean of 39.22

† Burdock, E. I., Hakerem, G., Hardesty, A.S., and Zubin, J.: A ward behavior rating scale for mental hospital patients. *J. Clin. Psychol.*, 16:246. (1960).

* Caudhill, W., Redlich, F.C., Gilmore, H.R., and Brody, E.B.: Social structure and interaction processes on a psychiatric ward. *Amer. J. Orthopsychiat.*, 22:314. (1954).

days. Nine of the patients in each group were diagnosed schizophrenic, seven anxiety state, three depressive reaction, one manic-depressive, one involutional melancholia, one postoperative psychosis, and one hysteria.

Results

The level of the inter-rater agreement is indicated by a product moment correlation coefficient of 0.70 obtained between the ratings of two nurses on both the first group and the second group of patients.

Each patient's score on the Ward Behavior Rating Scale was the mean of two of the nurses. The mean score of the 23 patients rated before desegregation was 110.91; the mean score of the 23 patients rated after desegregation was 118.93. The difference between these means is significant at the .01 level on a one-tail test of significance ($t = 2.525$ $df = 22$). Since the items on the Burdock Scale are scored zero or one, according to whether the behavior is maladaptive or not, the higher score of the second (post-desegregation) group indicates that the behavior of these patients was more adaptive than that of the patients in the first (pre-desegregation) group.

Discussion

The differences between the groups cannot be due to differences between the raters since each matched pair of patients was rated by the same nurses. The nurses did know, of course, to which group the patient belonged and this was not possible to avoid. This presents the problem as to whether the raters were influenced by this knowledge thus giving the post-desegregation group higher ratings. It is felt that the use of the Ward Behavior Rating Scale obviated this to a large extent since the items that make up the Scale are quite objective, e.g., "Does his ward chores in a satisfactory manner," "Is able to make own bed," "Writes letters to family or friends." There are 150 items on the scale and this, plus the length of time between the rating of a patient in the first group and the rating of his matched control in the second group, would make it difficult for any conscious distortion to take place. It is also noteworthy that the reliability of the ratings after desegregation was the same as prior to it. If there was an unconscious influence of the knowledge as to which group the patients belonged, one might have expected a difference in reliabilities.

The decision to desegregate the patients and the date of desegregation was decided upon for administrative reasons before the project was planned. For this reason, the project is not as adequate as one would have wished. A larger group of patients with, perhaps, separate analyses for various diagnostic categories would have provided more data. More important in the study, the two groups were unbalanced on the sex variable which was a result of the greater number of female admissions during the project. That sex may be an important variable is suggested by the finding that the male patients rated after desegregation obtained lower scores (were more maladaptive in their ward behavior) than their matched controls.

Summary

Two groups of 20 female and 3 male patients matched for age, sex, diagnosis, treatment and length of hospitalization were rated by two or three nurses on Burdock's Ward Behavior Rating Scale.

The patients in one group were rated before desegregation of the male and female patients, and the patients in the second group were rated after desegregation of the patients.

The mean score of the patients in the post-desegregation group was found to be significantly higher than the mean score of the patients in the pre-desegregation group suggesting that desegregation results in an improvement in ward behavior.

There is a suggestion that the sex of the patients may interact with the effects of desegregation thus indicating the need to manipulate the sex variable in any further studies that may be undertaken.

We wish to express our thanks to Dr. M. Reiskind, Director of the Munroe Wing, who permitted us to conduct the study, and to nurses E. Brouet, H. Frey and M. Haslett who rated the patients.

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THE NURSING ASSISTANT

DAVID R. BROWN, M.B., D.P.H.

Her struggle for certification and her possible future.

The origin of the principle of training hospital attendants in Ontario dates back to 1919 but a further 20 years elapsed before a six months' course for auxiliary hospital workers or nursing assistants was finally sponsored. Several proposals were put forward to improve the status of auxiliary nursing staff and to create a new entity — the certified nursing assistant. In 1946, a special inquiry was made by the Minister of Health into the problem of shortage of nursing personnel in Ontario. The suggested solution was the establishment of training schools and the provision for licensing of nursing assistants.

In that same year various meetings were held and attended by representatives of RNAO, OMA, OHA and the Department of Health. This committee approved the establishment of a nine-month course for the training of nursing assistants. It recommended that certain hospitals might conduct such courses. The Department of Education also became interested and set up similar programs. In 1947, legislation was enacted in Ontario to establish and protect the "Title of Certified Nursing Assistant."

Regulations provided for the setting up of these approved training centres. It had become obvious that uniformity in training was not only desirable but necessary to cope with this level of nursing in hospitals and homes, and also with the varying backgrounds of the auxiliary staff in respect of age, education, experience in this and other fields, differing objectives and potentials. The purpose of the program at this time was to "relieve and share the services of the nursing profession as a whole, due to the specialization of the nursing profession."

A further milestone was reached in 1951 by a committee of the Canadian Nurses' Association which was formed to study auxiliary personnel and, in particular, the problems concerned with the preparation, legislation and utilization of auxiliary nursing workers. At that time, the nursing assistant was defined as "one who has graduated from a recognized school for nursing assistants, and who assists with the care of the patient in hospital or home, under the direction of a physician or the direction and supervision of a registered nurse." The committee felt that the functions of the nursing assistant should be more specifically stated:

1. To assist with the care of patients in hospitals under the direction and supervision of a registered nurse.

2. To assist with the care of patients in homes under the direction and supervision of a registered nurse or the direction of a physician.

3. To practise hygienic care of the patients' environment and, where indicated, the required care of the home surroundings.

Some physicians prefer another definition of the nursing assistant:

1. A person trained to care for selected convalescent, subacutely or chronically ill patients.

2. A person trained to assist the professional nurse in a team relationship, especially in the care of the more acutely ill.

Since the Nursing Act of 1951, the strength of the certified nursing assistant group has expanded steadily from three approved schools to a total of around 30 agencies conducting training centres for Certified Nursing Assistants in Ontario. The number of assistants has now reached the proportions of a very formidable work force.

The Curriculum

At the outset,

the trainee should be oriented to her new role as a nursing assistant and her relationships with others in such a way that her interest is directed towards her patient and other persons. From a definition of health and the expansion of it, her new role with its resultant responsibilities can be developed. From this point, how she can fulfill her responsibilities and what she needs to know can follow. Here she is helped to realize that there are other people working with her who are contributing to the welfare of the patient also, such as the physician, nurses, including her supervisors, relatives, friends, the minister or priest, the occupational therapist.

The development of the nursing assistant should include insight into the steadily expanding field of bedside nursing; awareness of interpersonal relationships and of her contribution as a member of the nursing team. The increasing demands for hospital services, the advances in medical science, therapy and techniques, require a well trained and competent staff to care for patients. The more technical skills and, unfortunately, a considerable volume of administration are being delegated to the registered nurse, thus making the nursing assistant a very necessary link in the nursing chain.

The limitations of the nursing assistant lie only in function and in education. The assistant is deeply concerned with needs of the patient within the concept of comprehensive nursing care. The aim is that the assistant should acquire *good basic nursing care skills*. That is, she should be able to give good bedside nursing care to the average type of patient with no grave personality problems or more acute types of disability. The chief purpose for training this type of hospital worker is "to relieve and share the services of the nursing profession as a whole." Due to the increasing tendency towards specialization in her profession, the nurse really needs an assistant.

Emphasis should be placed upon the importance of harmonious and pleasant interpersonal relationships between the assistant and her patient, the assistant and her co-worker. The extreme importance of the proper approach to difficult situations, that the assistant should seek guidance if any uncertainty exists at all in any given nursing situation, is made very clear. During the first few months of training, much stress will be laid upon the realization by the student of her limitations, and how she must deal with this factor throughout her career.

Attitudes towards the nursing assistant vary from full to partial acceptance by the nursing profession. They are still suspect by some of us. But it is a fact that, under the direction of the registered nurse and the doctor, the nursing assistant is proving in every instance to be of distinct help in assuring total nursing care of the patient, and in helping to maintain and to promote the standards of the whole nursing profession. Much of the successful practice of the nursing assistant will be the result of the guidance and understanding of the registered nurse who is supervising her.

Present Status

The status of the certified nursing assistant is steadily increasing. Her activities are becoming better known; she enjoys a rightful place in the nursing team. However the nursing

assistant must not only retain that place but continue to improve through revision of studies, improvement in techniques, association with other nursing organizations, study groups and postgraduate courses. The opportunities for employment are evident in many places in the community: in all types of hospitals; in nursing homes; in public health agencies; industrial health units; in homes; in doctors' offices and, to those with the pioneering spirit, in Red Cross hospitals in the Far North.

The welcome mat should be out for a greater assimilation of male nursing assistants into the organization. The recruitment of unqualified male staff into hospitals is a matter of considerable concern. Very often these individuals are called upon to assist in many tasks pertaining to bedside care for which they have had little preparation. Is this not an area that should be developed in the future? I feel that many physicians would welcome the male nursing assistant to the hospital team, provided he has had the necessary training and is certified by examination.

The general expansion of hospitals produces a greater need for the services of certified nursing assistants. As the hospital grows in complexity, with more and more complicated facilities, it might well be that the specialized training of nursing assistants would contribute very materially to successful team working.

There is no doubt that the increasing hospital population is, in part, due to greater use of facilities by people coming into hospital earlier than previously not only for treatment but also to take advantage of increased diagnostic facilities. The increased life expectancy with the growing numbers of the population in the older age groups is producing the so-called "geriatric diseases" of the cardiovascular system, the respiratory system, central nervous system, and locomotor system. Geriatric care is becoming a very important area in our nursing community.

It has been proposed that the Ontario Hospital Services Commission should extend its activities into the field of domiciliary care. Various studies have been carried out by the VON and other public health agencies where nursing assistants have been employed in homes to look after patients and to work in a team relationship with the physician, a member of the VON or public health staff, or the district nurse. This would appear to be an enlarging field of importance.

The future of the nursing assistant must be directly influenced by the strength of its association, and by its cooperation with the Department of Health, the registered nurses' association and other interested organizations. Better public relations is required of the association to make known its objectives and aims, and to increase understanding of the nursing assistant's role. The last few years have seen progressive improvements in the organization of the certified nursing assistants. There is no question that the nursing assistant is entering a new phase in her career; that she is achieving a new status; that she is enjoying independent recognition in her own right and not merely, as one often hears, as a relief measure for the shortage of nurses.

What of the Future?

The certified nursing assistant, being an integral part of the nursing plan, has many opportunities to apply her skills and training in the hospital or the home. It has been suggested that the assistant might be given additional experience in the operating room, in pediatric or obstetric areas, and so take the equivalent of a postgraduate course in a particular specialty. Some hospital administrators welcome this idea, and feel that the policy should be advocated now.

More effort should be made to admit male students for training leading to certification. They would constitute a very valuable group in our hospital organization.

A single greatful thought raised to heaven is the most perfect prayer. — G. E. LESSING

School of Nursing
University of Ottawa

THE WORLD OF NURSING

PREPARED IN YOUR NATIONAL OFFICE, CANADIAN NURSES' ASSOCIATION,
74 STANLEY AVENUE, OTTAWA

Christmas Greetings

The president, Executive Committee, executive director and National Office staff of your Association extend warm Christmas greetings.

May a star of hope guide all of us to discover a calm strength of peace and an upsurging power of joy, that with COURAGE we may together venture forth into new ways of service and good will to all men.

As an association we can face our future tasks with confidence and courage as we take pride in some notable accomplishments of the past year.

Canadian Nurses' Foundation

The Canadian Nurses' Foundation was officially launched by the CNA in June 1962. This Foundation will solicit and administer funds with a view to accelerating the preparation of nurses at the master's and doctorate levels for leadership positions in Canada.

Last September, the Canadian Nurses' Foundation received a grant of $150,000 from the W.K. Kellogg Foundation, to be paid over a period of six years.

Eleven Canadian nurses have already received financial assistance from the Foundation and are presently enrolled in Canadian and American universities.

32nd Biennal Convention

The 31st Biennial Convention on the West Coast is over and plans for the 32nd Biennial Convention to be held in St. John's, Newfoundland are developing satisfactorily. It will be held at the beautiful new Memorial University in St. John's, June 14-19, 1964.

Post-convention tours now under consideration will include a tour to Europe, St. Pierre and Miquelon, the French island off the South Coast of Newfoundland, and an eight-day coastal tour of Newfoundland.

CNA Membership

The Canadian Nurses' Association now has a membership of 64,727, an increase of 905 since March 1962. This represents over 80 per cent of the registered nurses in Canada.

At the 31st Biennial Meeting in Vancouver in June, honorary memberships were conferred upon eight Canadians who have made an outstanding contribution to nursing. Three of these memberships were to persons from careers and vocations other than nursing. This raises the total honorary membership in the CNA to 33.

C.N.A.R.P.

During the past year the Canadian Nurses' Association Retirement Plan has become better known, and National Office has been deluged with requests for information and applications for membership.

Nursing Unit Administration

The NUA Course sponsored jointly by the CHA and CNA has now entered upon the second year of its program, with an increase in enrollment.

Seven Nursing Unit Administration Workshops were held in centres across Canada since the first of September.

A representative of your association brought greetings to the opening sessions at each conference. These workshops and correspondence courses are meeting an urgent need for preparation in leadership.

School Improvement Program

Plans are now well underway for the next phase of the CNA School Improvement Program. Workshops and institutes have been planned in each province for sometime in 1963. Consultants and resource people have been invited to participate. A total of twenty conferences will be held.

Briefs to Royal Commission on Health Services

A Brief and Supplementary Statement were submitted to the Royal Commission on Health Services in March and September 1962 respectively. Copies of the Brief may be purchased from National Office at $2.50 per copy.

IN THE GOOD OLD DAYS

(*The Canadian Nurse* — DECEMBER 1922)

The Student Christian Conference for the Central Provinces was held at Elgin House, Muskoka. There were present at the Conference students from all the universities and colleges in Ontario and Quebec, with representatives from the Maritime and Western Provinces. Among the delegations was one of eleven nurses, three from the Hamilton General Hospital and eight from the Toronto General Hospital, four of whom were representatives of the Training School.

Before the evening meetings, the various delegations met separately to consider problems relating to their own groups and to make plans for the coming year. The nursing delegation had most interesting discussions, and much thought was given as to the best way of carrying the spirit of the Student Christian Movement back to the hospital and making it practical in the busy everyday life. All the difficulties of long working hours, short recreation hours, physical weariness which the work produces, lack of time and opportunity for study, were brought up, but most of the delegation realized that if the members of the nursing profession were to take their places as worthwhile citizens in the community, the desire to make the most of life should be great enough to overcome these difficulties.

The Department of Public Health of the University of Toronto has entered the third year of its trial period. Forty-five students are enrolled, the majority of whom belong to Ontario, but there are also representatives from other provinces.

Many a desirable candidate is faced with the sad fact that she cannot meet the entrance standard of the department, and this should lead us to urge all girls to finish their high school course before entering the hospital training school. Many nurses now bitterly regret the neglected opportunity of their school days, and might justly reproach the guardians who permitted them to leave school unnecessarily early. We take special delight in the occasional student who has triumphed over adverse circumstances. This is usually the case of a girl who has been forced to leave school at the age of 15 or 16 because she was needed at home, and when she had only covered one or two years of high school work. Occasionally such a one has continued her studies under a tutor, has taken night school work, or in some way has reached the desired goal. Needless to say such a one makes a most desirable addition to the class.

The first classes in this department have set a high standard for their successors to follow. The nurses are already spoken of as a keen group of students.

NURSING PROFILES

The Canadian Nurses' Association has announced the appointment of **Thelma Pelley** as nursing secretary. A graduate of Toronto Western Hospital, Miss Pelley received a bachelor of science in nursing degree from the University of Toronto and a bachelor of arts degree from Memorial University, St. John's, Newfoundland.

She has had wide experience in nursing in both public health and institutional fields. Prior to her present appointment Miss Pelley was the clinical coordinator for the General Hospital of Port Arthur School of Nursing.

(LeRoy Toll, Toronto)

THELMA PELLEY

Minerva Snider, director of nursing, Stratford General Hospital, Ontario has been appointed to the Dominion Council of Health. A graduate of Kitchener-Waterloo Hospital, Ont., Miss Snider has had extensive experience in supervision and administration. Her duties at Stratford have included participation in planning for the new hospital that has since been completed under her administration.

In her capacity as a Council member, Miss Snider will be one of the five Canadians, apart from representatives of governments, who meet twice yearly to discuss matters in relation to health and welfare. She will represent English-speaking women's organizations acting in these fields.

MINERVA SNIDER

Earlier this year at the convocation of The University of Western Ontario, **Edith Mary McDowell** was awarded an honorary Doctor of Laws. As the first dean of Western's school of nursing, her efforts on its behalf were persistent and enthusiastic. The end result was a reorganization of the total program and introduction of the first Master's course in nursing in Canada. In addition to this she found time to supervise building plans for the new building that presently houses the school of nursing.

A graduate of Royal Victoria Hospital, Montreal, with a bachelor of science degree from Columbia University, Dr. McDowell also obtained a Master of Arts degree in administration in institutions of higher education from the same university.

In the words of the citation that preceded the award of the doctorate, she is "an inspiring teacher, an authoritative writer, an able administrator, and an educated lady."

A graduate of St. John's General Hospital, Newfoundland, **Rosalie (French) Lester**, has been appointed director of nursing services for the provincial division of the Canadian Red Cross Society.

ROSALIE LESTER

Following graduation, Mrs. Lester remained on the staff of her hospital where she did general staff duty for a time before succeeding to the position of head nurse. Since 1960 she has engaged in private nursing. Her new duties will include responsibility for the organization and conduct of home nursing classes in all parts of the province. In addition she will administer the Sick Room Supply Loan Service and supervise well baby clinics.

JEAN NEWTON

The Registered Nurses' Association of Nova Scotia has announced the appointment of **Jean Newton** as nursing secretary in charge of nursing education and services.

A graduate of the University of Cincinnati College of Nursing and Health, Mrs. Newton obtained a bachelor of arts degree from Greenville College, Illinois, and has been working towards her Master's degree at the University of Maryland. She has had much practical experience in professional work in a variety of positions — staff nurse, head nurse, supervisor, industrial nurse, school nurse. In addition she has taken an active part in the work of the state associations of both Delaware and Maryland.

As nursing secretary, Mrs Newton will work closely with the various schools of nursing in Nova Scotia.

(V. Garcia, Montreal)

BERNICE UNDERHILL

For some years now, Canadian nurses, who succumbed to the lure of Bermuda as the ideal spot to work, have come to associate the name of **Bernice Charlotte Underhill** as part of the answer to their dreams. As instructor, assistant matron and finally matron of King Edward VII Memorial Hospital in Bermuda, Miss Underhill served there from 1938-61. Last year she announced her retirement and returned to Montreal — but not to a life of leisure. She was appointed to the staff of the Montreal General Hospital — her Alma Mater — and eventually helped to develop the program that culminated in the opening of MGH's new School for Nursing Assistants. Early

this year Miss Underhill was appointed to the teaching staff of the hospital and, in her capacity as instructor, she will have much responsibility for the successful operation of the new school.

(Van Dyck, Montreal)

FRANCES SIKORA

The Alberta Association of Registered Nurses has created a new position in its organization — committee coordinator — and has appointed **Frances M. Sikora** to carry out the duties associated with it.

Miss Sikora graduated from the University of Alberta Hospital in 1952 and, after three years on the operating room staff, continued her studies at the University of Alberta. She obtained her diploma in teaching and supervision in 1956 and returned to her hospital as an instructor in operating room nursing for a two-year period. Later she was appointed instructor in basic science and eventually senior instructor. This year she completed requirements for her bachelor's degree in nursing from McGill University, specializing in nursing curriculum.

Miss Sikora has been a very active member of the provincial sub-committee on nursing education. Her characteristic energy, enthusiasm and love of hard work will be important assets in the development of her role as coordinator.

Maude Irene Dolphin is director of nursing, Nanaimo General Hospital, Nanaimo, B.C. In that capacity she has been very busy, in recent months, helping to plan and equip the new 200-bed hospital that has replaced the former institution in the area.

While nursing has been her chosen profession for a number of years, Miss Dolphin is also a trained musician. For some time before coming to the Royal Victoria Hospital, Montreal for her preparation as a nurse, she taught music in Nelson, B. C. In spite of her present busy schedule, she finds time to continue this earlier interest as a member of the Nanaimo Symphony Orchestra.

MAUDE DOLPHIN

Miss Dolphin attended the School for Graduate Nurses, McGill University after a two-year term on the staff of the Alexandra Hospital, Montreal. In 1953 she completed requirements for her bachelor's degree in nursing from McGill, majoring in administration. In 1961 she obtained her Master's degree from the University of Washington, Seattle. During the years 1953-59 Miss Dolphin served overseas with the World Health Organization in Pakistan, Syria and Mauritius.

In October, at an investiture held at Government House, Ottawa a number of nurses were invested by His Excellency, the Governor General, Major General Georges Vanier with their insignia in the Order of St. John.

Those receiving promotions were: **Evelyn Pepper**, nursing consultant, Emergency Health Services; **Blanche A. Emerson**, nursing consultant, St. John Council for Alberta. Those admitted to the Order were: **Mildred Walker**, nursing consultant Occupational

(Dominion-Wide photographs, Ottawa)

From left to right: F/L (N/S) JOAN FITZGERALD, Miss EVELYN PEPPER, Mrs. DOROTHY SLAUGHTER, Miss MILDRED WALKER, Major (N/S) HARRIET SLOAN, Miss BLANCHE EMERSON.

Health Services, Dept. of National Health and Welfare; **Dorothy Slaughter**, consultant public health nurse, B. C. Public Health Service; **Mrs. D. H. Slimmon**, provincial nursing officer, Manitoba St. John Ambulance Nursing Brigade; **Major (N/S) Harriet Sloan**, Canadian Forces Medical Services Training Centre; **F/Lt. (N/S) Mary Joan Fitzgerald**, Surgeon General Staff, Medical Personnel Directorate.

St. John Ambulance National Headquarters has also announced the 1962 recipient of the Countess Mountbatten Bursary — **Barbara Bennett**, a second year student at the University of Toronto School of Nursing. Those who received special grants were: **Wendy White**, U.B.C. School of Nursing, student; **Joan Eagle**, teaching staff, McMaster University School of Nursing; **Lucie Robidoux**, Ecole Notre Dame de l'Espérance, Montreal, student; **Elizabeth Lloyd**, Edmonton General Hospital, student; **Ruth Springate**, Sherbrooke Hospital, P.Q., student; **James N. W. Ruddock**, University of Ottawa, degree student.

(Campbell & Chipman, Winnipeg)

MAY WATANABE

The Ontario Division of the Canadian Red Cross Society has granted an award of

$1,000 to **May A. Watanabe**, a predoctoral student in sociology and nursing research at the University of Washington, Seattle. This award was offered to provide financial assistance to graduate nurses in Ontario to undertake studies at a degree level directed towards positions of leadership.

Miss Watanabe who holds her Master's degree in nursing from the University of Washington as well, was a lecturer in nursing at McMaster University. She is a member of the Canadian Association of University Teachers and the National Sociology Honor Society.

Gladys Gage, a lieutenant-colonel in the Salvation Army and a graduate of Grace Hospital, Windsor, Ont., has retired after 40 years in the hospital field. Her assignments in that time have taken her from Grace Hospital, Vancouver to Grace Hospital, St. John's Newfoundland. Excepting for a four-year period as a surgical head nurse in her home school, her work has been in the field of administration either as a director of nursing or as an administrator.

(Campbell & Chipman, Winnipeg)

GLADYS GAGE

The practice of her profession has been for Lieutenant-Colonel Gage a rewarding and enriching experience. Her many colleagues and friends extend best wishes for a full life in retirement.

In Memoriam

The alumnae association of Saint John General Hospital, N. B. pays tribute to the memory of **Ethelyn M. Armstrong** '16, for many years a staff member of the Victorian Order of Nurses, Saint John and to **Lillian (Kaine) Carlisle** '15.

* * *

Hazel Irene Gillies (Victoria Hospital, London '26) died earlier this year. She had engaged in private nursing.

* * *

Mary Whitelaw Hallam (Queen Victoria Hospital, Revelstoke, B.C., '34) died in Vancouver on September 13, 1962. She was a former staff member of the Willow Chest Centre in that city.

* * *

Deborah MacLurg Jensen (Johns Hopkins Hospital) died recently in Nantucket, Mass. Mrs. Jensen was a well-known nurse, educator and author. Many Canadian nurses will be familiar with such texts as *History and Trends in Professional Nursing* and *Principles and Practice of Ward Administration.*

* * *

Rosette (Letarte) Lacasse (Ste Justine's Hospital, Montreal) died on September 13, 1962. She served overseas during World War II with No. 2 Canadian General Hospital during the campaign in France, Belgium, Holland and Germany and eventually went to England as a member of No. 17 Canadian General Hospital. Mme Lacasse was associated with the Canadian Cancer Society in recent years.

* * *

The alumnae association of The Montreal

General Hospital pays tribute to the memory of **Annie Jane (Stevens) MacNutt** '16 and **Rachel McConnell** '14. Miss McConnell served overseas during World War I and was decorated with the Royal Red Cross. She was director of the school of nursing, Hartford Hospital, Detroit, 1924-41.

* * *

Sarah Agnes Maitland (Vancouver General Hospital '18) died on September 2, 1962. She had engaged in private nursing.

* * *

Violet McGill (Brockville General Hospital, Ont.) died early this year. For many years she was the assistant registrar of the Ottawa Central Registry.

* * *

Ann Elizabeth McKay (Hamilton General Hospital, Ont. '53) died recently. She was on the staff of Woodstock General Hospital, Ont. in the department of nursing education at the time of her death.

* * *

Gwendolyn (Paxton) McKee (St. Joseph's General Hospital, Vegreville, Alta. '40) died early this year. For a number of years she engaged in private nursing in Edmonton but latterly she was on the permanent night staff of Fairview Municipal Hospital, Alta.

* * *

Olive (Morton) McKelvie (Regina General Hospital '23) died in Nipawin, Sask. in August of this year.

* * *

The alumnae association of Kingston General Hospital pays tribute to the memory of the following graduates: **Kathleen (Blacklock) Moore** '12; **Estella Mary (Reid) Whitelock** '14; **Evelyn (McAuley) Zufelt** '28.

* * *

Aileen Victoria (Ganton) Parker (Winnipeg General Hospital '27) died on August 29, 1962.

* * *

Sister St. Ignace de Loyola, o.s.a., died early this year. She was on the staff of Hôtel Dieu du Sacré Coeur, Quebec City at the time of her death.

* * *

Jean Ewing Souter (Hamilton General Hospital, Ont. '21) died in August. She was retired from nursing.

* * *

Mrs. Audie B. Stewart (Toronto Western Hospital '34) died early this year in Ottawa after a long illness.

* * *

Dorothy (Brown) Swindells (Toronto General Hospital '35) died in September.

* * *

Marjory Valera (Nelson) Waterhouse (Brandon General Hospital, Man. '04) died early in 1962, in Carberry, Man. She was 86 years of age.

* * *

M. Louise (Meiklejohn) Lyman, a former superintendent of Lady Stanley Institute, Ottawa, died on August 27, 1962. Mrs. Lyman was made an honorary member of the Canadian Nurses' Association in 1958. She was then 94 years of age and had been the hostess of the meeting that marked the founding of our national association in 1908.

* * *

Anne Martin (Sydney City Hospital, N.S. '21) died on October 11, 1962 after a brief illness. She had retired from nursing early this year after 30 years of service as superintendent of Sydney City Hospital. Eight years of her career prior to that had been spent in private nursing. She had served her profession for a total of 41 years.

Mortality from heart disease in the past decade decreased at every period of life excepting early childhood and the older ages. Although there was an over-all rise in the recorded death rate from all forms of heart disease combined — from 358 per 100,000 in 1949 to 373 in 1960 — it merely reflected the growing ratio of older persons in the country. When allowance is made for this aging, mortality from heart disease actually showed a five per cent drop.

It is believed that the appreciable increase in heart disease deaths at preschool ages partially reflects the fact that a larger proportion of babies with congenital heart lesions benefit by modern treatment methods and survive beyond infancy, but then succumb during early childhood. Furthermore, a greater number of such cases are being diagnosed.

—Metropolitan Life Insurance Co.

* * *

A man should perform a righteous deed, even if he does so only for ulterior motives, because he will thus learn to do the right for its own sake. —TALMUD

THE NURSING ASSISTANT

DOROTHY MCKEOWN

Is she an intruder or a team-mate?

In the process of preparing this article, my unruly mind refused to stay in the present, and insisted on taking flight into the past. It was at the age of seven that I had my first encounter with a practical nurse. A stately woman, whose snowy-white hair competed with her cap and uniform in its whiteness, visited our home to assist the family doctor with the delivery of a baby sister. Needless to say, this gracious lady performed many functions in our household, but the one that left its imprint upon the mind of a young child was of a nutritive nature. She made the most delicious bread puddings ! For some time, in my small mind, the words "bread pudding" and "practical nurse" were somewhat synonymous.

May I take the precaution of noting that the thoughts which will follow are very definitely my own. It is quite possible that they do not reflect the thinking of any institution or association with which I am concerned.

I am sure that all nurses are young at heart and, therefore, it will not be necessary to apologize if I say : . . . Once upon a time, when medicine and nursing were very young, there lived twin sisters. Both young ladies were well-known in the community for their efforts on behalf of the sick. When the privilege of learning was extended to women, one of the sisters grasped the opportunity and, eager to be a part of the great humanitarian movement of her time, travelled to London, England, and there in St. Thomas's Hospital under the genius of Miss Nightingale, she flourished. This sister we shall call the Professional Nurse. But the main character in our fairy tale is the other sister.

Let us christen her the Practical Nurse. This sister loved to care for the sick, but the long years of professional training did not appeal to her. She gained some knowledge of nursing in her daily care of the patient but in most cases, like Topsy, she just grew and grew! As time went on, because of her aptitude and interest in nursing, the hospital as well as the community acquired her services. Some institutions went so far as to provide some on-the-job training but, generally speaking, her knowledge of nursing techniques depended upon what she could glean from doctors and professional nurses. It was often a trial and error method.

Gradually, both the nursing profession and the public became aware that there was a need for this practical nurse. Our heroine, however, did not come into her own until during World War II and the post-war years. This story, like all fairy tales, has a happy ending. The practical nurse became a certified nursing assistant and, with the help of her sister, the professional nurse, and a well-prepared inservice program by the hospitals in which she was employed, she became a valuable member of the health team. Throughout history this practitioner of the art of nursing has assumed many titles :

Aide, attendant, auxiliary nurse, subsidiary worker, auxiliary worker, vocational or non-professional nurse and nursing assistant.

In April 1954, with the enactment of the Nursing Assistants Act by the Governor and assembly of the Province of Nova Scotia, the practical nurse in this province obtained legal status. The established title for practical nurses or nursing assistants (who meet the requirements stated in the "Regulations for Nursing Assistants") is *certified nursing assistant.*

A certified nursing assistant may be:

1. A graduate of a school for nursing assistants.
2. A practical nurse who has practised for not less than two years and submits proof of same, and is able to furnish references from a doctor and a registered nurse. The waiver clause in respect to this type of applicant expired December 1960.
3. A graduate of a professional school of nursing who has not registered.
4. An undergraduate of a professional school — that is, one who has received a certain amount of training in a school of nursing.
5. A graduate of a special course, such as psychiatry, obstetrics.

The following information about the registrants in this province may be of some interest. Many of the female certified nursing assistants are married women. Male registrants are in the minority, numbering about 130. Approximately seven per cent of the total registrants have had some professional training; academic qualifications range from elementary school to university; ages vary from 18 to 69. It has been observed that many of the older women bring to nursing a maturity and experience which, in many instances, is most beneficial.

The first registration examinations for nursing assistants in this province took place in April, 1961. In a matter of a few years, a rapid growth has taken place in the area of practical nursing in Nova Scotia. The nursing assistant has advanced from an obscure position to an accepted place on the health team. Traditionalists have had some difficulty in accepting this fact.

I often wonder about the present environment in which both the professional nurse and nursing assistant carry on their duties. I am sure that future historians will note the influence of economics upon hospital organization. This seems to be the era of the hospital board, the administrator, the business manager and the budget. I am not, of course, questioning the necessity for all four, but may I express the hope that their influence will be kept in its proper perspective? How much this particular group will influence actual nursing care is something that must be observed closely by all those concerned with the welfare of the patient. The nursing assistant has the right to expect that the professional nurse will give leadership in this matter.

For some time there has been a tendency for nurses and the public to interpret nursing as the privilege of the professional nurse only. My own interpretation of nursing is a more general one. It would include as its participants all those who give nursing care to the patient. In the hospital there are many functions that can only be performed by the professional nurse. There appears to be two schools of thought in respect to the duties of the certified nursing assistant. In some institutions I suspect that the nursing assistant is given responsibilities far beyond her capabilities. In such instances it would seem that economic factors take precedence over the safety of the patient. No doubt some will say that this situation has arisen due to the shortage of professional staff. It seems to me that the word "shortage" is the most over-worked one in the vocabulary of the modern hospital. In other situations, the nursing assistant is permitted only to carry trays, answer the phone and clean rooms. What an extravagant waste of trained personnel!

Many nursing activities are relatively simple but can become quite complicated, depending upon the condition of the patient. Too often the professional nurse delegates duties to the nursing assistant that are far in advance of her preparation. Too often the nurse, faced with a multitude of duties, finds it necessary to make a choice between the ones that she intends to carry out and those which she will delegate to the assistant. I fear that, in some instances,

due to her choice, the patient is deprived completely of professional experience and understanding.

It seems to me that we might well ask ourselves if there is another reason why the nursing assistant sometimes assumes nursing duties beyond her preparation? Could it be possible that there are occasions when the nurse, due to indifference and the misinterpretation of some phases of nursing care, shirks her professional responsibilities? She may avoid actual contact with the patient as much as possible although, of course, she takes temperatures, dangles a stethoscope from her ears, carries a piece of equipment for an interne (who, incidentally, might very well have carried it for himself!). Incidentally, the special equipment might not have been necessary, if the nurse had observed her patient carefully. Nurses in the past were criticized for doing "too much" for the patients. It was felt that there should be a stage when the patient should be encouraged to do something for himself. It seems possible that the professional nurse occasionally applies this principle for her own purposes rather than for the welfare of the patient. It is true that we live in the "do-it-yourself" age, but must we adopt this method indiscriminately? Indifference on the part of the nurse who is caring for the patient, and unawareness on the part of the head nurse and director of nurses as to the quality of nursing care being carried on by the nursing staff, present a most hazardous situation for the patient. Thus is created an atmosphere in which the uncaring professional nurse and nursing assistant thrive.

In Regulations for Nursing Assistants in the Province of Nova Scotia it is provided that:

> In a hospital, sanatorium, nursing home or other institution, a Certified Nursing Assistant may perform functions of the practice of nursing only under the supervision of a Registered Nurse.

I do not think that this section could be interpreted to mean that the registered nurse should be at the elbow of the nursing assistant every time she performs a nursing duty. Not at all. But it does place definite responsibility for the supervision of the performance of nursing duties by the nursing assistant upon the shoulders of the professional nurse. Supervisors and head nurses should be thoroughly familiar with the preparation and ability of each member of their staff, and the individual needs of each patient. Upon this basis, the nurse-in-charge should be able to determine the responsibility that the certified nursing assistant can assume. The demands placed upon her must be reasonable and within her scope of preparation.

How often one hears the complaint that the nursing assistant is taking over the nursing care of the patient. My philosophy of nursing leads me to believe that there is sufficient room at the bedside of the patient for both the professional nurse and the nursing assistant. However, the professional nurse of the future will need to be proficient in many ways, not alone in performance of procedures. Since the nursing staff exists primarily for the care of the patient, and the reputation of the hospital depends largely on the quality of its nursing care, therefore it behooves hospital authorities to see that such care is achieved through intelligent supervision and the provision of an inservice program for the nursing assistant as well as the professional nurse.

Nursing is somewhat like the theatre. It has both tragedy and comedy. The leading role in the drama is played by the professional nurse. Should not the strong supporting role go to the certified nursing assistant? Administrators of nursing service are the directors of the drama. The success of the play depends upon their casting.

Every man's work, whether it be literature or music or pictures or architecture or anything else, is always a portrait of himself.

—SAMUEL BUTLER

Satire is a sort of glass, wherein beholders do generally discover everybody's face but their own.

—JONATHAN SWIFT

About Books

Pharmacy for Nurses by H. R. Mehta, Ph.D., 352 pages. Delta Publishing Company, P.O. Box 870, Boulder, Colorado. Ed. 3, 1962.
Reviewed by Sister Ste Rose, pharmacist and instructor in pharmacology, St. Joseph's Hospital, Sudbury.

This book contains valuable information and would be of much use to senior students and graduate nurses as well as to teachers of materia medica. It discusses at great length drugs and solutions, their uses and effects, and scientific implications. Junior students, however, who have not learned the importance of discriminating between different drugs will probably find the text beyond their understanding.

The title of the book may be misleading. Pharmacy is a distinct profession and to my mind should not be used in connection with nurses. *Pharmacology and Nurses* might be a more appropriate title.

The author has described fully the use of brand names, generic names and synonyms. Pharmacists realize and appreciate the distinction between these names but nurses cannot be expected to have acquired this knowledge. For example, tetracycline is the *generic* name approved by the Food and Drug Department in Canada for one antibiotic. Different companies choose a *brand* or trade name of their own for the same product. Therefore tetracycline may be represented as follows:

Achromycin (Lederle); Tetracyn (Pfizer); Panmycin (Upjohn); Stecline (Squibb's). These brand names are all synonyms for the same product.

Medical-Surgical Nursing by Kathleen Newton Shafer, R.N., M.A., Janet R. Sawyer, R.N., A.M., Audrey M. McCluskey, R.N., M.A. and Edna Lifgren Beck, R.N., M.A. 876 pages. The C. V. Mosby Co., St. Louis, Mo. Ed. 2. 1961.
Reviewed by Mrs. Ellenor Shellington, instructor, Vancouver General Hospital, Vancouver, B.C.

In this second edition the authors state that specific sections have been clarified by rearrangement and by the inclusion of subheadings. An interesting aspect in the care of the chronically ill is the inclusion of the "physical profile system" for planning nursing care. Much more has been added concerning fluid and electrolyte balance. The nursing care relevant to this is well correlated with basic facts.

Newer treatments are dealt with specifically: The use of the artificial kidney in renal failure caused by poisons; surgical procedures used in the treatment of metastasis in cancer of the breast. The nursing care of the patient following an endarterectomy is given in greater detail. These are only a few examples of material added.

In schools where every student does not have a text for each specialty there are chapters dealing with these which would give her a basic guide to help her understand the subject. This is especially true of the chapters dealing with diseases of the reproductive system and the care of the patient with mental illness.

This book could be used as a text for student nurses at all levels and as a general reference.

The Chief Nurse in the Small Hospital by Fauntella T. Jensen, R.N. 128 pages. The Ryerson Press, 299 Queen St. West, Toronto 2B. 1960.
Reviewed by Miss D. Hibbert, University of Saskatchewan, School of Nursing, Saskatoon, Sask.

The author's intentions were: To provide a guide to those already directing nursing departments; to stimulate others to explore leadership activities; to point out some of the "know-how" needed. She has ably accomplished these aims.

Basic principles of administration are emphasized though not separated from pertinent activities in which every nurse leader engages. The author writes with full realization that we work with human beings who will, at times, need to be guided and motivated by some external force, namely, their leader. Her suggestions are practical and acceptable to most employees. For example, page 79, "a few succinct rules regarding certain drugs must be posted in a conspicuous place. These will include automatic stop orders . . . for such drugs as narcotics, antibiotics and anticoagulants."

This book is small, indexed, readable, and economical to purchase. Readers should

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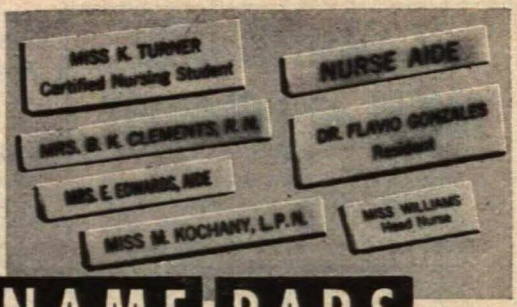

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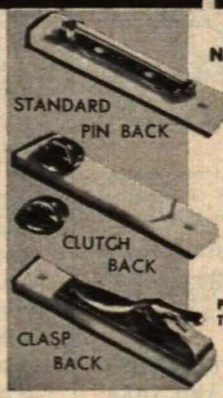

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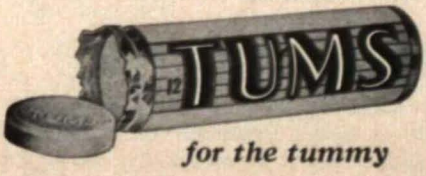


for the tummy

not be misled by the subtitle for it is literally crammed full of directions, suggestions and cues which any head nurse, supervisor or matron will find valuable.

The Conquest of Pain by Ronald Woolmer, M.D. 240 pages. McClelland & Stewart Limited, 25 Hollinger Road, Toronto 16, 1961.
Reviewed by Mrs. Helen P. Glass, 206 Park Towers Apts., 2300 Portage Avenue, Winnipeg 12.

With the great advances in surgery, it has become necessary for anesthesiologists to take over from Nature the regulation of the systems of the body : the lungs, brain, glands and the heart itself. Pain, a great deterrent in early surgical methods, has largely been brought under control. How the divorce of pain from surgery is achieved and how the vital systems of the body are being brought under increasingly precise control, is the subject of this book. Nurses will read with interest. The author has written about the complex systems of the body in the simplest language. In many places the book is delightfully story-like as he relates the developments in the history of anesthesia.

There is much value in the explanation of the physiological changes that take place in the body with the application of the various types of anesthesia and certain other drugs. Chapters on muscle relaxation and protection of the unconscious patient are particularly useful since they point out the reasons for many nursing measures performed for patients in the operating room and in the recovery room.

The new and exciting field of surgery on the heart and the controls which the anesthetist must have on the body systems during hypothermia and the use of the heart-lung machines are explored. Educators and students alike will find this particularly enlightening. The application of hypnosis as a surgical aid is explained simply. A discussion of artificial respiration is timely in the light of the many and increasing needs for its application.

The author has included simple drawings to explain such things as the by-pass of blood in heart surgery. Illustrations included are only fair, unless one is quite familiar with the complicated apparatus shown. However, they might serve to familiarize the lay reader with strange equipment.

The book is written so that a lay person can understand the mysteries of anesthesia. It might, however, be somewhat difficult

for them to grasp the import of the author's intent. Certainly, it is a book that would have great value for the student of nursing. I would recommend it for resource reading.

While reading this worthwhile publication, I was more than ever convinced of the need for nurses to read medical literature. Many of the changes brought about to facilitate patient care (and not always by nurses) might be more readily foreseen if interested nurses would explore the field of medical physiology to determine ways and means of improving care to the patient in the light of new advances in medical technology. The book is highly recommended as fascinating reading for nurses and lay persons alike.

Essentials of Neurosurgery for Students and Practitioners by Sean Mullan, M.D. 273 pages. Springer Publishing Company, Inc., 44 East 23rd St., New York 10. 1961. *Reviewed by Miss Carroll Legge, 495 Prince Arthur St. W., Montreal.*

The author has presented us with as complete an analysis of neurosurgery as is possible to compile in this concise manner. His purpose is to provide a basis of neurosurgical knowledge for medical students and practitioners.

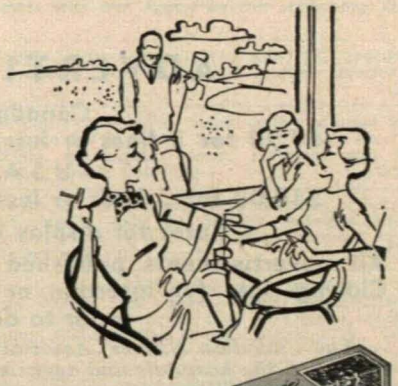
This is not a textbook for students of nursing. However, it would be an excellent reference book for clinical instructors and head nurses who work in a neurosurgical unit, as well as for postgraduate nursing students in this specialty. The chapters which would be particularly useful are those on cerebral seizures, brain and spinal tumors, head and spinal injuries, intervertebral disc diseases and cerebral aneurysms.

Nursing care, an exceptionally important aspect in the total care of a neurosurgical patient, is mentioned in the chapters on head injuries and fractures of the spine. Although this is directed toward the medical student and the practitioner it is regrettably brief.

The description of the mechanism of head and spinal injuries is extremely valuable because of its clarity and the simplicity of its diagrams. Indeed, the diagrams and statistical charts are the areas clinical instructors would find the most useful as visual aids in teaching. They are quickly accessible through a complete illustration index at the front of the book.

Dr. Mullan has met his stated objectives. Informally, he has dedicated the book "to those students who occasionally go to sleep during my noonday lecture." One wonders how this would be possible.

Matinée



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It's in the silent time of prayer, in happiness and in despair
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—Author unknown

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—Duc de la Rochefoucauld

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—*American Journal of Obstetrics and Gynecology.*

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General Duty Nurses for well-equipped 76-bed hospital in active town of 3,000. Salary $290 - $340 for Alberta registered; $280 - $330 for non Alberta registered. New separate residence, excellent personnel policies & working conditions. Apply to: Director of Nursing, Brooks General Hospital, Brooks, Alberta. 1-13-1

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Graduate Nurses for 60-bed modern hospital in resort area on Vancouver Island. R.N. basic $309 with yearly increments according to RNABC personnel policies. Enquiries: Director of Nursing, Campbell River & District General Hospital, Campbell River, British Columbia. 2-9-1

Graduate Nurses for 20-bed hospital, 35-mi. from Vancouver, on Coast. Salary & personnel practices in accord with RNABC. Bus & train transportation, accommodation available. Apply: Director of Nursing, General Hospital, Squamish, British Columbia. 2-68-1

Operating Room & Obstetrical Nurses, British Columbia registered, for modern 450-bed acute General Hospital, located on South Vancouver Island. Basic salary $309, credit for experience & postgraduate preparation, personnel policies in accordance with RNABC. For particulars write to: Director of Nursing Service, St. Joseph's Hospital, Victoria, British Columbia. 2-76-5

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Matron (Duties to commence as soon as possible) for 18-bed hospital. Salary range : $350-$410 in 4 yrs. Living-in accommodation $50 per mo. Apply in writing, giving age, experience & references to : Mrs. E. Green, Superintendent, Memorial Hospital, Crystal City, Manitoba. 3-16-1

Registered Nurses (2 immediately) for The Glenboro Hospital. Starting salary at present: $305 per mo. Starting salary effective January 1st, 1963: $330 per mo. Glenboro is situated on Manitoba Highway No. 2, midway between Winnipeg and Brandon. Good religious, social, recreational and sporting facilities available. Residence accommodation in 2 year old residence. Hospital is only 7 years old. Application forms and personal policy booklet mailed on request. Applications and enquiries to: Mr. S. A. Oleson, Box 310, Glenboro, Manitoba. 3-28-1

Registered Nurses (2) 25-bed hospital near Winnipeg. Salary $315 respectively, 40-hr.wk., vacation pay, 10 statutory holidays, room and board $45, $10 increment, yearly. **Registered Nurse** (1) with supervisory experience to assume duties of Director of Nursing, immediately, commencing salary $360. Apply to: Administrator, DeSalaberry Hospital District No. 27A, St. Pierre, Manitoba. 3-53-1A

Registered Nurses (2) for 42-bed hospital located 38 mi. from Winnipeg. 1963 salary schedule $325-$370 per mo., 3 annual $15 increments. Credit given for experience, 40-hr.wk., complete maintenance $45 per mo. in modern nurses' residence. Usual holidays and sick leave benefits. For further information and application forms, write to: Miss Josephine Giesbrecht, R.N., Director of Nursing, Bethesda Hospital, Steinbach, Manitoba. 3-59-1

Registered Nurses (2 immediately) for 32-bed General Hospital. General Duty. Basic salary January 1st $325, increases 2x$10, 2x15, 40-hr.wk., room and board $45. Apply: Superintendent, District Hospital, Virden, Manitoba. 3-67-1

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Registered Nurses for 34-bed hospital, min. salary $320, 3-wk. vacation with pay, sick leave after 6-mo. service. **Certified Nurses Assistants** salary $220, 2-wk. vacation with pay. **All staff** — 5-day 40-hr. wk., 9 statutory holidays, pension plan & other benefits. Apply to: Superintendent, Englehart & District Hospital, Englehart, Ontario. 7-40-1

Registered Nurses. Applications and enquiries are invited for general duty positions on the staff of the Manitouwadge General Hospital. Excellent salary and fringe benefits. Liberal policies regarding accommodation and vacation. Modern well-equipped 33-bed hopsital in new mining town, about 250-mi. east of Port Arthur and north-west of White River, Ontario. Pop. 3,000. Nurses' residence comprises individual self-contained apts. Apply, stating qualifications, experience, age, marital status, phone number etc. to the Administrator, General Hospital, Manitouwadge, Ontario. Phone: TAylor 6-3251. 7-74-1

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Registered Nurses for all services including Psychiatry and Operating Room. Salary range $305 to $335 per mo., personnel manual sent on request. Apply: Director of Nursing, The Wellesley Hospital, 160 Wellesley Street East, Toronto 5, Ontario. 7-133-49

Registered Nurses and Certified Nursing Assistants for modern 64-bed General Hospital. Apply to: Director of Nursing, Arnprior and District Memorial Hospital, Arnprior, Ontario. 7-4-1

Registered Nurses & Certified Nursing Assistants for modern 75-bed hospital. Starting salaries — R.N.'S $310 per mo., C.N.A.'S $220 per mo. Single room accommodation available in the residence. Dryden (population 6,500) an industrial town, also center of extreme tourist area, is conveniently located midway between Winnipeg & the Canadian Lakehead. For further information regarding personnel policies, community activities, etc. please call or write: The Director of Nursing, Dryden District General Hospital, Dryden, Ontario. 7-36-1

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Registered Nurses & Certified Nursing Assistants for 160-bed accredited hospital. Starting salary $320 & $220 respectively with regular annual increments for both. Excellent personnel policies including 5-day wk. Ontario hospital pension plan. Residence accommodation available. Assistance with transportation can be arranged. Apply: Director of Nurses, Kirkland & District Hospital, Kirkland Lake, Ontario. 7-67-1

Registered Nurses & Certified Nursing Assistants for 26-bed hospital. R. N. minimum salary $320, maximum $370, 28-day vacation after 1-yr. C.N.A. minimum salary $232, maximum $265, 2-wk. vacation after 1 yr., 3-wk. after 2 yr. Credit for past experience, $5.00 increment every 6 mo., 40-hr. wk. 8 statutory holidays. Room & board $45 per mo., 1-day sick leave per mo. Apply to: Mrs. G. Gordon, Superintendent, District Memorial Hospital, Box 37, Nipigon, Ontario. 7-87-1

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Registered Nurses for General Duty for modern 40-bed hospital in resort town on beautiful Lake Huron. Starting gross salary $300, 40-hr. wk., 10 working days sick leave in 1 year, 50% unused sick leave paid at end of year, 50% single OHSC, PSI and Group Insurance paid, 8 statutory holidays, 4-wk. vacation after 1 yr., board and room $30, modern living quarters. Apply: Superintendent, Saugeen Memorial Hospital, Southampton, Ontario. 7-122-1

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Registered Nurses for General Duty in modern 18-bed Private Hospital in iron mining town, 140 miles north of Sault Ste. Marie, Ontario. Starting salary $310 min. to $360 max., less $20 per mo. maintenance. Recognition for experience up to 3 years. Good accommodations & personnel policies. Transportation allowance after 6-mo. **Operating Room Nurse** starting salary $364 min. with postgraduate course to $414 max. with recognition for experience. Apply: Superintendent of Nurses, Lady Dunn Hospital, Wawa, Ontario. 7-140-1

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General Duty Nurses for 100-bed modern hospital, southwestern Ontario, 32 mi. from London. Salary commensurate with experience & ability; $300 basic salary. Residence accommodation available. Pension plan. Apply giving full particulars to: The Director of Nurses, District Memorial Hospital, Tillsonburg, Ontario. 7-131-1

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Nurses with certificate in public health, required by Stormont, Dundas & Glengarry Health Unit in the Seaway Valley area. Generalized program. Minimum salary $3,700, annual increment, allowance for experience, 5-day wk. Employer-shared surgical group benefits, pension plan & Ontario Hospital insurance, 3-wk. vacation, cumulative sick leave benefits, car allowance. Apply in writing giving qualifications & experience to: Miss Glenna French, Supervisor of Nurses, Box 1058, Cornwall, Ontario. 7-34-5

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Public Health Nurses — Salary range $3,780-$4,440, consideration given to experience, uniform allowance, fringe benefits. Apply to: District Director, Victorian Order of Nurses, Greater Montreal Branch, 1246 Bishop Street, Montreal 25, Quebec. 9-47-53

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Registered Nurses, Staff Nurses for permanent positions, various departments, days, eves., nights. Excellent starting salary, increments, benefits and working conditions in one of the largest and finest general hospitals in the West. For details write: Personnel Department, Queen of Angels Hospital, 2301 Bellevue Avenue, Los Angeles 26, California. 15-5-3G

Registered Nurses for private 258-bed hospital for men, women and children. Staff Nurse salaries from $355-$435, differentials for evenings, nights, communicable disease, operating room and delivery. Opportunities in all clinical areas. Holidays, vacations, sick leaves and health insurance. California registration required. Applications and details furnished on request. Contact: Personnel Director, Children's Hospital, 3700 California Street, San Francisco 18, California. 15-5-4

Registered Nurses General Duty for 230-bed approved teaching hospital, resort city. Starting salary $350 plus $22.50 shift differential, provision for housing allowance. Apply: Director of Nursing, Cottage Hospital, Santa Barbara, California. 15-5-39

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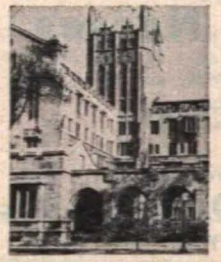

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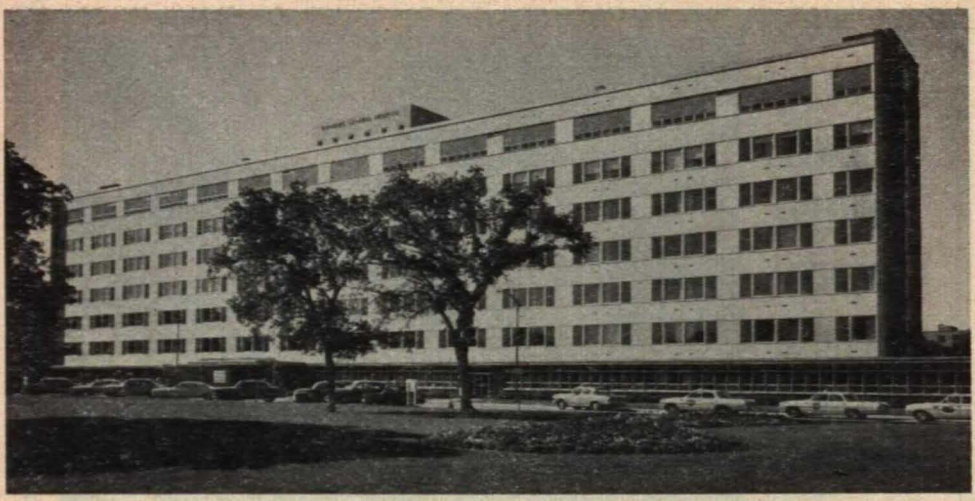

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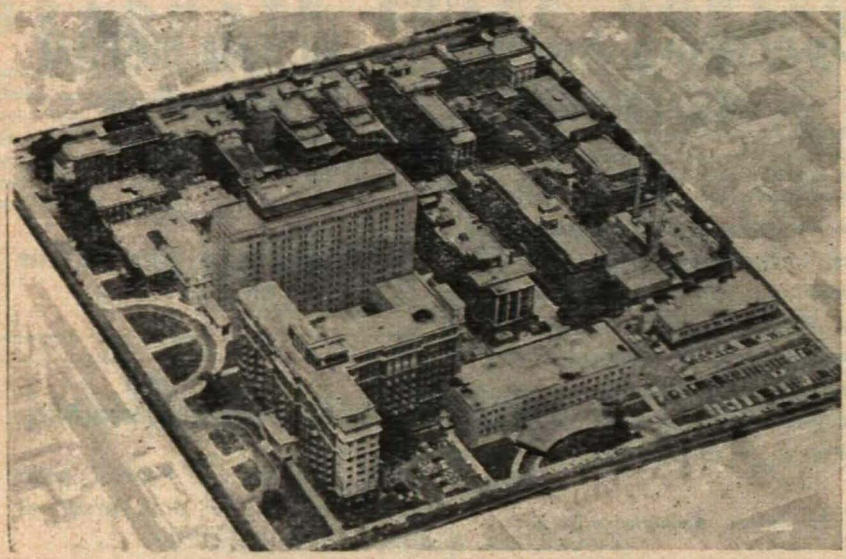

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Clinical Instructor for Obstetrical Department

Salary: $355-$435 per month commensurate with qualifications. Alberta registration. Credit for past experience.

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Salary: $290-$345 per month. Alberta registration. Credit for past experience and postgraduate work. Experience available in all Departments.

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Staff now being considered for opening of new 600-bed active treatment hospital early in 1963.

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for general duty to fill fall vacancies.

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Full range of benefits.

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for

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For modern 100-bed General Hospital in St. Lawrence Seaway community.

Applicants must have wide nursing experience and preferably, university preparation in nursing administration. Good personnel policies, salary commensurate with experience and qualifications.

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Apply to:

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requires

GENERAL STAFF NURSES

for

OPERATING ROOM
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Apply

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Operating Room Nurse
and

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82-bed hospital. Situated in the Niagara Peninsula. Transportation assistance.
For salary rates and personnel policies

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for General Hospital located in attractive community one hour from downtown Ottawa. Good personnel policies, employer participation in pension plan and other benefits.

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*Niedelman, M. L. and Bleier, A.; Jour. Ped., 37:5, 762, Nov. 1950
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1. Marks, M.M.: Am. J. Digest. Dis. 18:219, 1951

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